

1 Monday, 18 November 2024

2 (9.50 am)

3 **LADY JUSTICE THIRLWALL:** Ms Brown.

4 **MS BROWN:** Yes, we are calling Ms Dodd this
5 morning.

6 **LADY JUSTICE THIRLWALL:** Ms Dodd, would you like to
7 come forward?

8 MS SHARON DODD (affirmed)

9 Questions by MS BROWN

10 **LADY JUSTICE THIRLWALL:** Do sit down.

11 **MS BROWN:** If you could please state your name.

12 **A.** Sharon Dodd.

13 **Q.** You provided a statement to the Inquiry dated
14 20 June 2024 and is that true to the best of your
15 knowledge and belief?

16 **A.** It is.

17 **Q.** Turning to your qualifications, you qualified
18 as a Registered General Nurse in November 1979 and as
19 a midwife in May 1981?

20 **A.** That is true.

21 **Q.** You became a Registered Health Visitor in
22 1987?

23 **A.** I did.

24 **Q.** In terms of your career, from 1980 to 1987 you
25 worked as a midwife at the Countess of Chester Hospital?

1

1 **Q.** Turning then to your role in 2015/2016, what
2 safeguarding training did you receive for that role?

3 **A.** For the role of?

4 **Q.** The role where you were -- we will come to it,
5 but paediatric liaison nurse but also you were working
6 with CDOP, I think one day a week, the Child Death
7 Overview Panel?

8 **A.** Okay. As a health visitor you receive -- as
9 in any of my professional roles I have received quite
10 a lot of safeguarding training. But for that particular
11 role I was needing to, required by virtue of the role
12 that I was doing to actually complete Level 1, Level 2
13 and Level 3 of safeguarding training, which is
14 documented in the intercollegiate document and Working
15 Together to Safeguard Children.

16 **Q.** Was Level 3, that was the top of the
17 safeguarding training?

18 **A.** Yes, and in actual fact you can actually do
19 Level 4 training, but I didn't at that time.

20 **Q.** In terms of how practically that happened, was
21 that in-person training or online training?

22 **A.** No, so at that time it was all face to face.

23 **Q.** Can you recall when that was delivered and
24 whether -- how often you would have updates of that
25 training?

3

1 **A.** Yes.

2 **Q.** You subsequently worked as a health visitor?

3 **A.** Yes.

4 **Q.** Have you at any point in your nursing career
5 worked on a neonatal ward?

6 **A.** Never.

7 **Q.** In 2010 you commenced your role as
8 a specialist nurse in what is now the Cheshire and
9 Wirral Partnership NHS Foundation Trust in the
10 safeguarding department?

11 **A.** I did.

12 **Q.** You stayed in that role until 2019?

13 **A.** Yes.

14 **Q.** Are you still working within the NHS?

15 **A.** Yes. In 2019 I retired and then returned
16 part-time to a slightly different role.

17 **Q.** Is that a paediatric liaison role?

18 **A.** Yes.

19 **Q.** So that is no longer within the safeguarding
20 department and no longer within the CDOP?

21 **A.** I am actually based within the safeguarding
22 team but I am paediatric liaison health visitor, yes.

23 **Q.** Do you still have any involvement with the
24 Child Death Overview Panel?

25 **A.** No.

2

1 **A.** You have to have updates regularly and it was
2 delivered regularly and actually as part of the
3 safeguarding team I used to deliver the Level 3
4 safeguarding training as well at that time.

5 **Q.** When you say "regularly", how often are we
6 speaking about?

7 **A.** Level 3 training is -- in that kind of role
8 you would be expected to update every year.

9 **Q.** You said you were delivering the training?

10 **A.** I would deliver training as well, yes.

11 **Q.** Were you receiving training every year as
12 well?

13 **A.** Yes.

14 **Q.** Who was giving you that training?

15 **A.** The -- my colleagues from the safeguarding
16 team but also at that time from what was then called the
17 LSCB, Local Safeguarding Children's Board, we would be
18 expected to attend relevant training delivered by the
19 Local Safeguarding Children's Board as well.

20 **Q.** When you are talking about your colleagues,
21 specifically who was --

22 **A.** Within the safeguarding training where
23 I worked we delivered the training as part of the
24 safeguarding team.

25 **Q.** Who specifically was training you, do you

4

1 recall?

2 **A.** Do you want names, or?

3 **LADY JUSTICE THIRLWALL:** Yes, please.

4 **MS BROWN:** Yes.

5 **A.** At that time in my team there was
6 Satwinder Lotay, Jill Cooper, Karen Pygott, Steve Lee,
7 there was a whole team of us.

8 **Q.** Was there anybody who was working at the
9 Countess of Chester who was giving you safeguarding
10 training?

11 **A.** No, nobody at all. We were completely
12 separate. Cheshire and Wirral Partnership Trust deliver
13 their own training, Countess of Chester deliver their
14 own training, so there was no overlap in training.

15 **Q.** Within that training, and I am talking then
16 about the training you were receiving but also the
17 training you were giving, do you recall any training
18 making reference to cases such as Beverley Allitt or
19 Harold Shipman?

20 **A.** Absolutely. Actually, as part of delivery of
21 training we would include relevant serious case reviews
22 and relevant information that we would impart to people
23 that we were training. But also we would be receiving
24 that training from other areas, certainly the LSCBs to
25 deliver a lot of training around, you know, serious case

5

1 I think your time was split and you worked four days
2 a week as a paediatric liaison role; is that correct?

3 **A.** That's correct, yes.

4 **Q.** Very briefly, what did that aspect of your
5 role involve?

6 **A.** The paediatric development role was developed
7 as a result of the Victoria Climbié Inquiry many years
8 ago and it stated at that time, amongst other things,
9 that district general hospitals should have a paediatric
10 liaison health visitor who would be the conduit between
11 the hospital and the community in order to relay any
12 relevant information around children's attendances. So
13 that was the main thrust of the role that I would be
14 looking at, A&E attendances, Accident & Emergency
15 attendances for children under the age of 18 and giving
16 some level of scrutiny to those attendances. And also
17 within our Trust we also looked at children who
18 potentially might have life threatening illnesses or
19 long-term illnesses that might benefit from additional
20 support within the community and therefore we would be
21 relaying that information as well.

22 So any child on the children's ward who may have
23 a new diagnosis, say, of a malignancy we would be
24 relaying that information quite quickly to their
25 community practitioner so that they were aware of that

7

1 reviews that were relevant.

2 **Q.** You say "serious case reviews", but very
3 specifically were you trained and referred to the case
4 of Beverley Allitt?

5 **A.** Absolutely, yes.

6 **Q.** So were you familiar -- maybe not with the
7 number of the recommendation, but were you familiar with
8 the recommendation of the Clothier Inquiry into
9 Beverley Allitt that all those caring for children
10 should be aware of the possibility of malevolent
11 intervention as a cause of unexplained clinical events?

12 **A.** Yes.

13 **Q.** That was something that you were familiar with
14 as a concept?

15 **A.** We were familiar with, yes.

16 **Q.** In your Child Death Overview Panel role, you
17 were looking at the full range of causes of death of
18 children: natural, accidental and deliberate harm?

19 **A.** Yes.

20 **Q.** I think you have probably given the answer but
21 just to confirm was deliberate harm by a healthcare
22 professional something that was alert to you as
23 a possibility?

24 **A.** Yes.

25 **Q.** Just looking at how your role was divided,

6

1 and could support the family more robustly.

2 **Q.** When you are talking about liaison there, the
3 hospital you are talking about here is the Countess of
4 Chester?

5 **A.** Countess of Chester but also regionally. So,
6 for example, if a child attended an A&E department in,
7 say, Devon, they would send me the information around
8 that child's attendance and likewise if we had a child
9 in the Countess of Chester who lived in Devon, for
10 example, we would send it to them.

11 **Q.** Yes. Then turning to the one day a week that
12 you were worked as a Child Death Overview Panel nurse.
13 Did that division then, the four day/one day division,
14 did that remain the same from 2010 to 2019 when you were
15 in that role?

16 **A.** More or less. Some -- some weeks you would
17 actually be doing more of one than the other but they
18 did overlap quite nicely because of the -- being
19 a conduit between the hospital and the -- and the
20 community actually was quite -- quite seamless in that
21 respect.

22 **Q.** The Child Death Overview Panel was a minority
23 aspect of your role, was it?

24 **A.** It could -- it could be, but some weeks you
25 might be doing more of that than paediatric liaison. It

8

1 would just depend on what was actually happening at that
2 time, so if there was a Rapid Review Meeting, for
3 example, for a child death then you would prioritise
4 that.

5 **Q.** Just so that we can understand the set-up, the
6 Child Death Overview Panel that you sat on was the
7 Pan-Cheshire Child Death Overview Panel?

8 **A.** That's correct.

9 **Q.** That covered four areas: Cheshire East
10 Cheshire West and Chester, Halton and Warrington?

11 **A.** That's correct.

12 **Q.** They were the four areas.

13 That Pan Cheshire Child Death Overview Panel was
14 chaired by Hayley Frame?

15 **A.** At that time.

16 **Q.** At 2015/2016?

17 **A.** Yes, during that time I sat on the panel
18 I think there were three or four independent chairs but
19 at that time, yes, I think Hayley Frame.

20 **Q.** At that panel, when the panel sat, each of the
21 four areas would be represented by a specialist nurse
22 and you were the nurse for the Cheshire West and Chester
23 area?

24 **A.** That's actually not quite true because not
25 every area had a specialist nurse. So Warrington didn't

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1 **Q.** In terms of what the Child Death Overview
2 Panel were doing, they were not determining the cause of
3 death because that was for the Coroner or the doctor who
4 signed the medical certificate?

5 **A.** That's correct, that's right.

6 **Q.** The Child Death Overview Panel sat and
7 considered a case once all the other processes had
8 happened so after an Inquest or after an investigation
9 and then the Child Death Overview Panel came at the end
10 of that process?

11 **A.** That's correct and it could actually be quite
12 some time after the, the -- you know the child had sadly
13 passed away, it wasn't always very quick.

14 **Q.** Just looking at the specific role that the
15 Child Death Overview Panel was doing. That was set out
16 in the Working Together policy and I think you refer to
17 this in paragraph 9 of your statement.

18 **A.** Yes.

19 **Q.** But what the Working Together policy says is
20 part of the role of the CDOP, the Child Death Overview
21 Panel, was doing was to learn lessons to prevent further
22 deaths and to identify any wider public health or safety
23 concerns arising from a death or from a pattern of
24 deaths?

25 **A.** That's correct.

11

1 always have a specialist nurse but they did have
2 a specialist nurse employed at some point during the
3 time I sat on the panel and Halton didn't have
4 a specialist nurse.

5 **Q.** But when you sat you were sitting specifically
6 in relation to Cheshire West and Chester?

7 **A.** That's correct.

8 **Q.** Also on the panel there were designated
9 doctors from different areas?

10 **A.** That's correct.

11 **Q.** Dr Mittal was the doctor from the Countess of
12 Chester?

13 **A.** That's correct.

14 **Q.** As well on the panel there were local
15 authority representatives?

16 **A.** Yes.

17 **Q.** And also police who sat on that panel?

18 **A.** Yes.

19 **Q.** One of the police members was Detective
20 Superintendent Wenham?

21 **A.** That's correct.

22 **Q.** The panel, when they reviewed child deaths,
23 they would meet quarterly; is that approximately right
24 from your recollection?

25 **A.** More or less quarterly, yes.

10

1 **Q.** I think in your statement, you helpfully
2 paraphrase it and you say it involves establishing and
3 you refer particularly to any emerging patterns of
4 death?

5 **A.** That's correct.

6 **Q.** Now in addition to sitting on the panel when
7 that sat approximately quarterly with the other
8 representatives we have spoken about including the local
9 authority and the police, you say in paragraph 11 your
10 role was to disseminate learning and provide training
11 depending on what was identified in the panel.

12 **Q.** Who were you disseminating that learning to, who
13 fell within your remit of people you were giving
14 training to?

15 **A.** Because I was employed by Cheshire and Wirral
16 Partnership Trust my -- my learning would be very
17 definitely disbursed within Cheshire and Wirral
18 Partnership Trust. However, because we were a Pan
19 Cheshire panel, we would have wider training days and we
20 would actually have conferences where anybody could
21 attend who worked in that locality and, you know,
22 multi-agency, multi professionals and we did actually
23 have a few conferences where it was open for people to
24 attend. It didn't matter what your role was but you
25 could attend those panel -- those training events.

12

1 Q. So obviously we are concerned particularly
2 with staff at the Countess of Chester. Would they be
3 people that you would be disseminating your learning to
4 or be attending those conferences --

5 A. I wouldn't specifically disseminate learning
6 to the Countess of Chester but I would support
7 Dr Mittal. If he wanted to do some training sessions
8 then I would support him. But he would be responsible
9 for disseminating learning in the Countess of Chester.

10 Q. Can you just give an indication of one or two
11 of the sort of training or learning you are talking
12 about here so we are talking in actual real events?

13 A. Some -- some of the training packages were
14 about completing forms accurately and well so that the
15 panel could actually review the case robustly really
16 because there were in the beginning people
17 didn't really fill in forms terribly well. So there was
18 definitely learning needing to be disseminated around
19 that so that we could actually review the deaths better.
20 Because sometimes in the early days we didn't have
21 electronic forms so people would have a paper copy and
22 maybe just tick a box, there would be no sort of real
23 dialogue in there.

24 So some of the training involved completing forms,
25 the relevance of completing forms and the purpose of

13

1 back and look but I can't remember the specific dates
2 without looking -- around the use of the SUDIc protocol
3 because it had been identified by the CDOP panel that
4 the SUDIc protocol was not always used correctly in
5 hospitals.

6 Q. We will come to the SUDIc in a moment. But
7 that -- you recall there being training that you and
8 Dr Mittal did to improve that?

9 A. We did.

10 Q. At paragraph 12 you talk about the
11 administrative aspects of your role as a Child Death
12 Overview Panel nurse?

13 A. Mm-hm.

14 Q. And focusing specifically on deaths on the
15 neonatal ward at the Countess of Chester. I just want
16 to go through the stages of how the notification and the
17 forms operated.

18 Now, in very broad overview, and correct me if
19 I get this wrong, Form A was the form that set out the
20 details that the death occurred, that was the initial
21 notification form?

22 A. Form A was the initial notification form and
23 it was actually quite brief.

24 Q. Following Form A, Form B was then the form
25 that would be filled out about the relevant

15

1 completing the forms, really, which I don't really think
2 in the early days of CDOP panels people properly
3 understood because --

4 Q. Sorry --

5 A. Go on.

6 Q. You mentioned speaking to Dr Mittal?

7 A. Yes.

8 Q. Can you recall any of the training that you
9 did in conjunction with him?

10 A. He would be part of all of the training
11 packages, particularly the ones where we did a whole day
12 of training and we one of them specifically we did
13 around bereavement as well, he was involved with that.
14 He was involved with disseminating the information about
15 the Form Bs. I do recall him spending an hour or so in
16 the A&E department one morning at the handover for the
17 doctors to actually discuss the actual whole child death
18 protocol with them so that they fully understood it.

19 I don't know what he did specifically in the
20 Countess but I also did some training with him around
21 the neonatal unit much later around --

22 Q. When you say "much later", when are we
23 talking --

24 A. Probably about the end of 2017, I can't
25 remember the date specifically -- I could probably go

14

1 circumstances of the death and in the case of a neonatal
2 death that would be predominantly by midwives,
3 obstetricians and the neonatal doctors?

4 A. Yes. The Form Bs from my perspective would be
5 completed by health professionals. The Form Bs would
6 also be completed by other relevant professionals, so
7 they might also be completed by the police, they might
8 also be completed by social care or education but my
9 role was specifically around the Form Bs being completed
10 by health professionals.

11 Q. Then the form C was what was filled in after
12 the panel had considered the case?

13 A. That's right.

14 Q. I am just going to ask some questions as to
15 how that operated in practice and to understand that
16 process I think it's important and if you can confirm
17 that the Child Death Overview Panel who would consider
18 a case that was dependent on where the family lived, not
19 where death occurred?

20 A. That's correct.

21 Q. Wales had a similar system but that was
22 referred to as the Child Death Review. You may not be
23 familiar with that?

24 A. Sorry, say that again?

25 Q. Wales had a similar system where Child Death

16

1 Overview Panels, it was the Child Death Review?
 2 **A.** Yes, I think Wales was actually called PRUDIC.
 3 **Q.** I think that was for sudden death?
 4 **A.** Yes.
 5 **Q.** But in terms of the CDOP equivalent?
 6 **A.** I -- I can't comment on that because I never
 7 had anything to do with --
 8 **LADY JUSTICE THIRLWALL:** There is no need for you
 9 to --
 10 **A.** -- the process in Wales.
 11 **LADY JUSTICE THIRLWALL:** -- do that.
 12 **MS BROWN:** We are going to go through now, Ms Dodd,
 13 the notifications that you received in this case and if
 14 I could just remind you not to refer to the actual areas
 15 that parents lived in, so we will use the terminology of
 16 parents living within the catchment area of the Pan
 17 Cheshire panel or outside the catchment area.
 18 **A.** (Nods)
 19 **Q.** So regarding first Form A. How would that in
 20 fact how would that information receive you, would it be
 21 emailed or --
 22 **A.** At that time --
 23 **Q.** -- sent to you?
 24 **A.** -- it wasn't always by email. We had a lot of
 25 paper, unfortunately, still in 2015/2016. Now it would

17

1 you would be informed of it?
 2 **A.** The Form As would come to me yes, that's
 3 correct.
 4 **Q.** So going through now the specific babies that
 5 were on the indictment and that this Inquiry are
 6 concerned with, and this is paragraph 29 of your
 7 statement, it may be helpful if you have that in front
 8 of you?
 9 **A.** Mm-hm.
 10 **Q.** Baby A we see as you have just alluded to,
 11 that in that case you were notified of the death by
 12 a nurse and you in fact completed the form?
 13 **A.** That's correct. She then did send it to me
 14 afterwards.
 15 **Q.** Then you subsequently received a completed
 16 Form B and then that was sent on to the Pan Cheshire
 17 Child Death Overview Panel because Baby A did live in
 18 catchment?
 19 **A.** That's correct.
 20 **Q.** I think it would be helpful if we just look at
 21 these forms so we can see actually how this was
 22 operating. So if I could turn to INQ00001942.
 23 My Lady, this is tab 7 at your bundle?
 24 **LADY JUSTICE THIRLWALL:** Thank you.
 25 **MS BROWN:** So we are going to have on the form here

19

1 all be electronic. But at that point it could be paper.
 2 But it might actually be a phone call. So sometimes if
 3 a child had died, for example in Alder Hey, they may
 4 ring me and say this is -- this child has sadly died and
 5 I would fill in a handwritten Form A but they would then
 6 forward theirs.
 7 **Q.** We will come to that in moment but I think
 8 that is what happened in fact in relation to Baby A?
 9 **A.** It is indeed, yes.
 10 **Q.** Would all deaths, all neonatal deaths that
 11 occurred at the Countess of Chester, always be referred
 12 to you in the first instance; regardless of where that
 13 child lived, would they always come to you in the first
 14 instance?
 15 **A.** They might not come to any -- in the first
 16 instance they might have gone to Dr Mittal. He was the
 17 designated doctor for safeguarding and child death so he
 18 may have received the information before me. I would be
 19 the conduit to inform community practitioners, the LSCB
 20 and the designated nurses and my senior managers.
 21 **Q.** So as the conduit, even if it was Dr Mittal
 22 who was informed first you were -- you were the central
 23 funnel; it would always come via you?
 24 **A.** I would get those Form As, yes.
 25 **Q.** So if there was a death in the neonatal unit,

18

1 in a moment what is Form B in relation to Child A. And
 2 we can see there at the top we have got Child A, in fact
 3 when that's been added as a redaction for the purposes
 4 of this Inquiry, but there would have been a number
 5 there so it was anonymised?
 6 **A.** There would have been a number because when
 7 you reviewed the deaths at panel they were completely
 8 anonymous so nobody had an idea who that child was or
 9 where they were from.
 10 **Q.** And working down that form, and this of course
 11 is the Form B that was subsequently sent to the Child
 12 Death Overview Panel we know on 4 August, we see where
 13 was the child at the time of the event in the middle of
 14 the form and that's marked as the neonatal unit, and
 15 then we see further down the circumstances of the death,
 16 and we see that the midwifery did fill in a section some
 17 of that's been removed because of sensitivities.
 18 Then HV, so that is the health visitor, and if we
 19 turn over the page, we can see no additional information
 20 is available, health visitor didn't have an involvement
 21 sadly with the baby had died in the hospital.
 22 Then the GP, again not aware of any immediate
 23 circumstances leading to the death but sets out some of
 24 the maternal history and then really the substance of
 25 the form is filled out by the hospital as one would

20

1 expect with the neonatal death and they set out the
2 circumstances and then there is a summary of the
3 hospital report?

4 **A.** (Nods)

5 **Q.** Ensuring that that information was complete,
6 that in a sense was a key part of your role, was it?

7 **A.** I would send out, as it's documented in
8 Working Together that the designated person would
9 actually send out those Form Bs and will identify who
10 they should go to from the CDOP panel so the CDOP
11 administrator would often send them out they would come
12 back to me to make sure they were all completed and then
13 the whole package would be then sent to CDOP.

14 So we would resend the Form A and the Form B to
15 ensure that the CDOP administrator actually had all the
16 information that we could possibly give her.

17 I didn't analyse the forms because they are not my
18 information, so I would ensure that the people that had
19 been sent them had returned them and if they didn't
20 return them in a timely manner, we would chase them up.

21 **Q.** Then you would send it either on to the Child
22 Death Overview Panel of the Pan Cheshire, if that was
23 a within catchment baby, or to the relevant area if it
24 was a without catchment?

25 **A.** That's correct.

21

1 filled it in on other forms, can we simply forward that
2 information to you as CDOP rather than filling in yet
3 another form and I think we see from Mr Mittal that he
4 had spoken to you and we have agreed we will not ask the
5 paediatrician to complete Form Bs for cases where
6 a postmortem has been requested, we will instead use the
7 information from the dictated letter?

8 **A.** That's right.

9 **Q.** That was a practice you adopted?

10 **A.** Occasionally, yes, because the -- we would
11 find that that information as Dr Gibbs had identified
12 was duplicated. It's a lot of work for the
13 paediatricians -- well, for anybody to complete the
14 Form Bs, they really do need to be robust.

15 So actually if they were completing a referral for
16 a postmortem or for a discharge letter, for example,
17 which may go even to the parents, there would be a lot,
18 a lot of information in those referrals or letters and
19 we would -- we did discuss that at CDOP panel and
20 actually agreed that some of those letters actually had
21 a lot more information in them than what some
22 paediatricians would put in the Form Bs.

23 So we agreed that they could be used in those
24 circumstances and so what would then happen is they
25 quite often used to go straight to CDOP, actually, very

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1 **Q.** The form goes on to list -- we don't need to
2 go to all the pages but it goes on to list details, for
3 example family details such as siblings, the service
4 provision, so whether for example the police had been
5 involved, whether in certain cases a hospice would be
6 involved and then maybe we could look at page 6,
7 because you have referred to the bereavement services.

8 We can see there is a section on bereavement
9 services and that would be filled in and also to
10 consider whether that was a positive or a negative
11 experience so that was another section of the form?

12 **A.** That's right.

13 **Q.** Yes, that can go down now, thank you.

14 We have seen and if we can turn to an email, this
15 is INQ 0103110. I'm not sure if we have that on the
16 system. We do.

17 So this is an email, Ms Dodd, you have been shown
18 this but you weren't copied into this email?

19 **A.** No.

20 **Q.** But I am taking you to it just because it does
21 refer to you and it's an email exchange between
22 Dr Mittal and Dr Gibbs with some other people copied in
23 and it's discussing the filling out of the Form B and
24 the essence of the email is that Dr Gibbs is saying we
25 have all this information elsewhere, we have already

22

1 often they didn't come to me, and they would be
2 considered at panel, when we reviewed that child, all
3 together.

4 **Q.** We can take that down now, thank you.

5 At this point, so just the dates, so this was the
6 end of September 2015 --

7 **A.** (Nods).

8 **Q.** -- that Dr Mittal is recording the fact that
9 he had discussed with you about these forms. What was
10 your relationship with -- your working relationship with
11 Dr Mittal? How often would you be communicating with
12 him?

13 **A.** I -- I would say that my working relationship
14 with Dr Mittal was good. He would let me know if -- if
15 things were going on. He would let me know of child
16 deaths if he knew before I did, vice versa.

17 I used to see him at all of the CDOP panels.
18 I didn't see him on day-to-day basis by any means,
19 I might see him once or twice a month maybe but yes,
20 I would say that we did have a good working
21 relationship.

22 **Q.** On this occasion, so in about September he's
23 been discussing with you forms. Did Dr Mittal then in
24 September -- we know now that by that stage there had
25 been four neonatal deaths within a very short period,

24

1 within a two-month period, in fact three of those deaths
2 within an even shorter period.

3 Did Dr Mittal discuss that with you, discuss
4 concerns about the increased mortality or concerns about
5 the number of deaths on the neonatal ward?

6 **A.** He didn't discuss any concerns as -- as
7 I recall.

8 We may have discussed that there were three or four
9 neonatal deaths but we didn't discuss that there were
10 any concerns around those deaths and certainly the
11 information that I received didn't alert me to any
12 concerns around those deaths and I do think he would
13 have said so at the time. I do -- I would have expected
14 him to and I would -- I would have thought he would have
15 done.

16 **Q.** If we can go back, then, to page 6 of your
17 statement, going through the receipt of forms. So we
18 have looked at Baby A's Form B and Baby A was
19 communicated to you by phone and Form A completed and in
20 due course Form B.

21 Baby C, the Form A was completed and sent to you
22 but that baby was out of catchment area, so those forms
23 were sent to a different panel?

24 **A.** Yes.

25 **Q.** And Baby D likewise didn't -- you were
25

1 I wasn't there and indeed anybody within our
2 safeguarding team could have done that.

3 **Q.** If we can go then to paragraph 20 of your
4 statement. You say there and I am just going to read
5 that out:

6 "I kept a log of all forms received for the purpose
7 of my role with CDOP whilst at CWP [Cheshire and Wirral
8 Partnership] and as a result I became aware of 19
9 neonatal deaths between June 2015 and June 2016. Of
10 those neonatal deaths, I was informed that 13 neonates
11 died at the Countess of Chester Hospital neonatal unit."

12 We have seen on the form that would be something
13 that would be shown the place of death. Two died at the
14 Countess of Chester labour ward, two neonates died at
15 Arrowe Park neonatal unit, one neonate died at Liverpool
16 Women's Hospital NNU and one died at Claire House
17 Hospice in Wirral.

18 So you were keeping a log?

19 **A.** (Nods)

20 **Q.** And that's a significant number of deaths, 13,
21 and perhaps particularly significant set against the
22 fact that just two neonatal deaths in Arrowe Park and
23 one neonatal death in Liverpool Women's Hospital.

24 You had been in the role since 2010. Had you ever
25 seen that number of neonatal deaths coming from one unit

27

1 informed but that was a baby that was out of area, out
2 of catchment, so that wasn't dealt with by your CDOP
3 panel?

4 **A.** No.

5 **Q.** Baby E, again you were informed the combined
6 forms were sent and you forwarded those on accordingly?

7 **A.** Mm-hm.

8 **Q.** Baby I, like Baby A was a within catchment
9 baby, so Form A you say was completed, Form Bs were
10 completed and they were sent to the panel on
11 26 November?

12 **A.** Mm-hm.

13 **Q.** Then Baby O and Baby P, were you informed,
14 were you the conduit for those?

15 **A.** No, I wasn't. I -- I don't know why I didn't,
16 I wasn't informed about those. It may have been that
17 I was on annual leave or it may have been that I was
18 doing something completely different and my senior named
19 nurse Jill Cooper dealt with those. I didn't have
20 anything to do with them.

21 **Q.** So you personally didn't deal with those?

22 **A.** No.

23 **Q.** But they went through the same conduit?

24 **A.** They will have gone through the same system,
25 yes, because my colleagues would have covered my role if

26

1 before?

2 **A.** No, there was definitely an increase and we
3 actually did discuss that. We -- we as a safeguarding
4 team we were responsible for providing an annual report
5 and we actually did note it in the annual report as well
6 and we made sure that the LSCB and the designated nurses
7 were aware of that but unfortunately none of the --

8 **Q.** Just going back to that, so we can just take
9 it in stages.

10 When did you discuss it, when were you discussing
11 the concern?

12 **A.** I think we have got the date in here actually
13 that we discussed it with the Commissioners.

14 **Q.** Well, we discuss it much later, we will come
15 to a meeting in March --

16 **A.** Yes, several months later --

17 **Q.** That was the one you are referring to the
18 documents?

19 **A.** Yes.

20 **Q.** But not earlier than that?

21 **A.** Not that early on. I mean, I think the
22 timescale was quite broad and certainly as well it
23 spanned over two financial years which potentially may
24 have made us not look at it quite as robustly as maybe
25 we could have done at that time.

28

1 Q. What was the significance of a financial year
2 when you had 13 deaths?

3 A. Because we will have kept our spreadsheets for
4 in a financial year sort of format, if that makes sense.

5 Q. Well --

6 A. So we will have gone from 1 April until
7 31 March one year and then the 1 April until 31 March
8 the next year and so CDOP would certainly count those if
9 all of those baby deaths had been reviewed at CDOP they
10 would all have been counted.

11 Q. Just -- just pausing there for a moment. So
12 we have understood that they weren't all reviewed by the
13 same panel because of the catchment area issue. But as
14 far as you were aware, you had a list of 13 neonatal
15 deaths?

16 A. Yes, we did.

17 Q. We have gone through the fact that the Child
18 Death Overview Panel was there, one of its purposes was
19 to spot a pattern. This was a pattern, wasn't it?

20 A. It -- it without question yes, and certainly
21 with the benefit of hindsight you can look back and say
22 yes, this was very alarming.

23 At the time there was nothing to indicate to us
24 that there was a concern and certainly nobody ever said
25 to me that there was anything to be worried about on the

29

1 it wasn't.

2 We did discuss the child deaths with Paula Wedd,
3 who was one of the senior Commissioners, with Dr Mittal
4 because she was questioning as well why we hadn't picked
5 up something and actually we said --

6 **LADY JUSTICE THIRLWALL:** When was that?

7 A. I -- we have got the date here.

8 **LADY JUSTICE THIRLWALL:** You are being asked at the
9 moment about --

10 A. Yes, I know but 16 March 2017, it was.

11 **LADY JUSTICE THIRLWALL:** So that is quite a bit
12 later.

13 A. Yes.

14 **LADY JUSTICE THIRLWALL:** But I think what you are
15 being asked about is you kept a log of all the forms and
16 you became aware of those 19 deaths?

17 A. That's correct, yes.

18 **LADY JUSTICE THIRLWALL:** I think that is the
19 timescale I was asking you about, so if you can help us
20 about that?

21 A. I -- we didn't have any indication that there
22 was anything to be concerned about. The information
23 that we had was that the babies were -- many of them
24 pre-term, many of them unwell, many of them
25 unfortunately quite sick. We didn't have any indication

31

1 neonatal unit. Nobody ever mentioned that until much,
2 much later on.

3 Q. Well, just looking at that a moment. The
4 Child Death Overview Panel, because it was there to look
5 at patterns, and because you have identified you as the
6 conduit were the person who could identify that pattern
7 you have identified it?

8 A. (Nods)

9 Q. Why were you not then referring that on in
10 June 2016 or at some point before that once you started
11 to become aware of a pattern as it built four then five
12 deaths, and so on? Why were you not referring that, at
13 that point, to the Child Death Overview Panel or to
14 someone?

15 A. That's a very good question and I can't --
16 I can't say why we didn't do that at the time. I do
17 know that part of the issue was that they didn't all
18 live in our local area and therefore maybe we didn't see
19 quite as robust a pattern as we potentially could have
20 done.

21 I think it's very difficult to answer that question
22 for what we did at that time. I think now we would
23 definitely act differently, I think every child death
24 now would be referred to our CDOP panel. At the time
25 that wasn't the process and I don't know why potentially

30

1 that --

2 **MS BROWN:** Just pausing there a moment, Ms Dodd.
3 You just explained that the Form Bs that came in with
4 the details, that that was that something that you
5 considered or was that something that you sent on for
6 consideration?

7 A. We sent them on for consideration. It wasn't
8 my role to analyse the Form Bs.

9 Q. You have been referring to "we" as being
10 aware?

11 You were the conduit and they came to you?

12 A. Mm-hm.

13 Q. Who else was aware of this log that you were
14 keeping? Who else would have been aware of that log?

15 A. My managers, the designated nurse for
16 safeguarding.

17 Q. Can you give names where possible?

18 A. Anne Eccles was at that time the designated
19 nurse for safeguarding. She would have been aware of
20 every single death, the LSCB would have been aware of
21 every single death. Sian Jones, we used to copy her
22 into every -- every single death.

23 Q. Would Hayley Frame as the Chair of the CDOP
24 panel, would she have been aware of what was on your
25 log?

32

1 A. No, she wouldn't have been, because that
 2 was -- the reason I kept -- we kept a spreadsheet log
 3 was purely to -- well, to understand who we were dealing
 4 with but also to manage the Form Bs so that we actually
 5 had a timeframe for the Form Bs to come back to us. So
 6 if they hadn't come back we would actually have a sort
 7 of a way of managing those because otherwise there is no
 8 way that you could possibly keep track of all the
 9 requests that you had ever made for all of the Form Bs.
 10 So we used to manage that -- we used to manage that
 11 spreadsheet purely so that we knew if we had a Form A we
 12 now if there was going to be a serious -- a Rapid Review
 13 Meeting, we knew who may have been invited, we knew who
 14 we had sent the Form Bs to and when we expected them
 15 back so that we could follow them up.
 16 Q. Did you, once you had observed this as you
 17 have accepted I think pattern and the list -- the
 18 growing list of numbers, did you -- was that something
 19 you debated with Dr Mittal at any point?
 20 A. We did discuss can with Dr Mittal, yes, and it
 21 was --
 22 Q. In March 2017, but we are talking about in
 23 2016?
 24 A. I don't recall discussing a cluster of deaths
 25 with him. I don't -- I may -- I think we may have said
 33

1 exclamation marks:
 2 "Brilliant role ... Sharon has developed the role.
 3 Really good system, health visitors will call Sharon
 4 about any worries."
 5 That is what you started off your evidence with
 6 explaining the liaison role you did with the hospital
 7 and the community in terms of any concerns relating to
 8 children.
 9 Then if we could go over the page it seems then the
 10 interview turns to look more in relation to your CDOP,
 11 the Child Death Overview Panel, role and it says there
 12 four lines down:
 13 "Although nurse for CDOP, not good system for child
 14 death."
 15 You then go on to talk about bereavement support.
 16 Can you recall what you were referring to there
 17 when you are saying "not a good system for child death"?
 18 A. This, this meeting was really brief, really
 19 brief and what they were asking me about specifically
 20 was my paediatric liaison role and I actually informed
 21 them about the CDOP role. They didn't ask me about it,
 22 I informed them. And so they basically were just asking
 23 me what the -- what sort of -- what I did about it.
 24 Q. And what do you think, when you say "not
 25 a good system" do you think you said that and if you
 35

1 oh, not another neonatal death or something like that.
 2 But we never ever had the information that there was any
 3 concerns. So all of the Form As that we received didn't
 4 alert us to any concerns.
 5 Q. They alerted you [to] a pattern but you say
 6 not to a concern.
 7 A. Yes, and I think at the time because they
 8 didn't alert us to concerns, they didn't alert us to
 9 a pattern, if you see what I mean.
 10 Q. Well --
 11 A. I know that there was a number of deaths but
 12 we didn't see an emerging sort of pattern of deaths.
 13 Q. Can we go forward then to September 2016 when
 14 you are interviewed by the RCPCH and this is INQ0014605
 15 and that's tab 9, my Lady, in your bundle.
 16 So what's going to come up on screen here are the
 17 notes that were made by Sue Eardley of the RCPCH and
 18 this was an interview she had with you on
 19 2 September 2016 and we can see your name -- sorry have
 20 we got the right -- sorry, it's page 19 of that
 21 document.
 22 We can see your name "Sharon" and your role
 23 "Paediatric Liaison CDOP Pan-Cheshire". Then I think
 24 the interview it seems starts with discussing your
 25 liaison role and in fact towards the end we see with the
 34

1 did, what did you think was not a good system at the
 2 panel?
 3 A. Not a good system for child death. I don't
 4 know what that, I really -- I don't know why they have
 5 said that, I --
 6 Q. Did you at the time have reservations at all
 7 about the CDOP system?
 8 A. I don't know what that really refers to, to be
 9 honest:
 10 "Although nurse for CDOP, not good system for child
 11 death. She doesn't do it but gets school nurse and
 12 health visitor to do that."
 13 I honestly don't know what that means.
 14 Q. Did you though at the time have concerns about
 15 the CDOP system that you might have been referring to?
 16 A. No, I don't think so. I -- I don't know what
 17 that -- I honestly can tell you now I don't know what
 18 that refers to. I don't know what it means. It is very
 19 sort of -- it doesn't have any context to it, does it?
 20 Q. You go on to talk about bereavement. Just
 21 very briefly, what was your view of the bereavement
 22 services at the time in relation specifically to parents
 23 who had a child who died on the neonatal ward?
 24 A. I personally don't think that the bereavement
 25 services at that time were very good and we really,
 36

1 really tried within the CDOP process to improve
2 bereavement services and we developed partnerships with
3 some other agencies, particularly Alder Hey. We just
4 didn't have --

5 **Q.** When was that, when were these partnerships
6 being developed?

7 **A.** Was it what, sorry?

8 **Q.** What timing are we talking about? You said
9 you developed partnerships, when was that?

10 **A.** It was throughout the time that I was on the
11 CDOP panel really and we actually did have -- we did go
12 to Alder Hey to one of their bereavement panel -- one of
13 their bereavement training sessions so that we could try
14 and replicate it.

15 We just we don't have specific bereavement services
16 and we rely on charitable or other organisations to do
17 that. Our community teams will visit families and offer
18 support and we -- you know, if we have a child that dies
19 in a -- you know an educational age, then I know that
20 the Sky team will now provide help and support and
21 signposting for schools, but at that time the
22 bereavement services in my view at that time were not as
23 good as they potentially could have been.

24 **LADY JUSTICE THIRLWALL:** Do you think that might be
25 what that note is about?

37

1 **A.** I thought that I knew that the hospital had
2 had an internal Inquiry because CDOP had been informed
3 about that.

4 **Q.** What was that Inquiry?

5 **A.** Around the cluster of deaths and my
6 understanding was that the review was on the back of
7 that.

8 **Q.** So you are being interviewed about the cluster
9 of deaths and you are saying --

10 **A.** I was being interviewed.

11 **Q.** Higher than average?

12 **A.** I was being interviewed at that time about the
13 paediatric liaison role. That is what they asked me to
14 attend for. They didn't ask me to attend in my CDOP
15 role but I told them about it.

16 **Q.** And looking then just further down that note,
17 having spoken about the higher than average neonatal
18 deaths, you say they could speak to Hayley Frame, so you
19 are referring them to speak to her if they wish?

20 **A.** Yes, because I think they -- I think
21 I indicated to them that -- that the deaths wouldn't
22 have been reviewed at panel at the time. So that the
23 panel may have had the Form A and Form Bs but the deaths
24 may not have been reviewed at panel and therefore that
25 may be why I suggested to her that she spoke to

39

1 **A.** I don't know, maybe that potentially is, yes.
2 It doesn't make sense to me that sentence and I never
3 got the minutes for this meeting and only saw -- I only
4 saw the completed report months afterwards. And
5 I literally was in and out of that meeting honestly in
6 about five minutes.

7 **MS BROWN:** Because you go on to talk about
8 bereavement so it's possible, is it, that what you felt
9 was not a good system was related to the bereavement or
10 maybe you can't assist.

11 **A.** Possibly, yes.

12 **Q.** And if we go on then at the bottom of that
13 page you talk about the Form A and B explain Form A
14 arriving quickly and then information on Form B is
15 robust.

16 Then there is an entry "across Cheshire", an upward
17 arrow, so increase in number of deaths April 15 to 16.

18 **A.** Mm-hm.

19 **Q.** Then if we could go over the page:

20 "Neonates seem to have had higher than average but
21 none congenital abnormalities."

22 This is you informing the RCPCH?

23 **A.** Yes.

24 **Q.** What did you understand the RCPCH review was
25 doing?

38

1 Hayley Frame.

2 **Q.** We see then down the note:
3 "CDOP not worried nor is Sharon."

4 Do you think, looking back now, you should have
5 been worried at that point by the number of neonatal
6 deaths?

7 **A.** I don't think I would ever have said that,
8 that I wasn't worried, I -- I really don't think I would
9 have said those words and I don't know why that's been
10 documented. I -- I -- I never -- I had never saw the
11 minutes for this meeting until I had them for the
12 Inquiry.

13 **Q.** Did the meeting and fact that the RCPCH were
14 looking at a cluster of deaths and you are being
15 interviewed and you end up discussing CDOP, did that not
16 act as an alert to you that maybe this is something that
17 CDOP should be looking at because there was a pattern
18 here and it was worrying?

19 **A.** Absolutely and it did get discussed at CDOP.

20 **Q.** But not until March and this was September?

21 **A.** I can't -- I honestly can't remember the dates
22 that we did discuss things at CDOP without -- without
23 looking at the actual CDOP minutes specifically but
24 potentially not. But, again, even this, even the
25 Royal College review didn't -- nobody ever said to me:

40

1 we are very worried about these deaths, would you not be
2 worried about them? Nobody ever said anything about
3 being concerned about events on the neonatal unit.

4 **Q.** Then going down on that as well, it seems then
5 there was a discussion about unexplained, we see are:

6 "Any CDOP neonatal deaths unexplained?"

7 Then there is reference to the Pan Cheshire SUDIC
8 protocol. There is a comment:

9 "Will look back and see what were UE [it is not
10 clear whether that is unexpected or unexplained] from
11 Form As."

12 Is that a reference to you going back to see if
13 some of those deaths were unexplained or unexpected?

14 **A.** I would imagine that must be what it meant.

15 But it's just -- there's no context to the -- to the
16 minutes, are there?

17 I -- I assume these are the -- the only minutes
18 that they have got.

19 **Q.** These are just the notes from --

20 **A.** Yes.

21 **Q.** -- Sue Eardley.

22 **A.** Because at the time, I didn't see them,
23 I wasn't given them and only saw them when you sent them
24 to me.

25 **LADY JUSTICE THIRLWALL:** Honestly, we do understand

41

1 never ever indicated at panel meetings either that there
2 was.

3 **Q.** If we can just go to then see what the actual
4 report said?

5 **A.** Yes.

6 **Q.** So if we could go to INQ 0009618 at page 21,
7 so this is an extract --

8 **A.** Of the actual report, yes.

9 **Q.** -- from the RCPCH review, the October 2016
10 final copy confidential version. We see that they
11 address -- it will come up in a moment -- the child
12 death process.

13 It says there in relation to unexpected -- under
14 the heading "Child Death Process":

15 "Where an unexpected paediatric death occurs the
16 paediatrician contacts the senior investigating officer
17 for neonates. The designated doctor is notified. He is
18 responsible for advising Pan Cheshire Child Death
19 Overview Panel."

20 So that's Dr Mittal --

21 **A.** Yes.

22 **Q.** -- advising the Child Death Overview Panel
23 whether the deaths are expected or unexpected.

24 Was that operating in practice?

25 **A.** It should do, yes.

43

1 that point.

2 **A.** Yes.

3 **LADY JUSTICE THIRLWALL:** I think they were in
4 manuscript as well then have been typed up.

5 **A.** So it's very difficult looking at this now to
6 say what these minutes actually completely meant. We
7 can make assumptions, but I don't think we can --

8 **LADY JUSTICE THIRLWALL:** But I think you probably
9 did say you would go back and see what were --

10 **A.** I potentially did.

11 **LADY JUSTICE THIRLWALL:** That looks likely, yes.

12 **A.** And I probably did, actually, I probably would
13 have done because that's sort of person that I am,
14 I would go and check something, I would robustly look at
15 something.

16 **MS BROWN:** Do you think you would have reported
17 back to the panel about this interview and the concerns
18 that now are not only on your log but we are now -- you
19 are now also aware that the RCPCH are carrying out
20 a review in the hospital of the cluster of deaths?

21 **A.** I potentially might have spoken to Dr Mittal
22 about it and actually said to him, you know, is there
23 anything we should be concerned about? Is there
24 anything going on?

25 He never ever indicated to me that there was and he

42

1 **Q.** Did it in fact operate in practice as far as
2 you were aware?

3 **A.** I don't ever recall him having any concerns
4 and saying anything. In actual fact, I don't know
5 whether Dr Mittal was directly informed by the
6 paediatricians of every unexpected death. I can't
7 answer for him.

8 That is the process and that is what should have
9 happened or should happen. I don't know whether in
10 reality it did because unfortunately these -- you know,
11 the neonatal deaths occurred in the Countess. Dr Mittal
12 worked in the Countess, I didn't.

13 **Q.** Then if we can go down, we see at 4.4.25:

14 "The RCPCH Review Team was concerned that CDOP did
15 not appear to be alert to the cluster of neonatal deaths
16 and for at least some there should have been a Rapid
17 Response Meeting for notification."

18 Then:

19 "In their recommendation CDOP should consider
20 whether its processes could have detected the cluster of
21 deaths and initiated external review more swiftly."

22 Now, Ms Dodd, you were aware of the cluster of
23 neonatal deaths. Do you think -- do you accept that
24 that an external review should have been initiated more
25 swiftly as a result of that knowledge of the cluster?

44

1 A. Absolutely. Looking back now, absolutely.
 2 Q. There is also mention there in that report of
 3 the unexpected notification Rapid Response Meeting where
 4 there was an unexpected death. Turning to SUDiC, were
 5 you familiar with the SUDiC protocol?
 6 A. Yes.
 7 Q. What was your understanding as to whether the
 8 SUDiC process applied to the death of a neonatal baby
 9 born in hospital? Who died unexpectedly?
 10 A. Well, it would apply.
 11 Q. You were clear about that and throughout the
 12 period of 2015 to 2016 as far as you are aware there was
 13 an unexpected death in hospital, the SUDiC process
 14 should have been initiated?
 15 A. Absolutely. The SUDiC protocol at that time
 16 was documented by the then LSCB. It was clear. It was
 17 quite a lengthy document and I understand that, you
 18 know, if you were on any kind of department or A&E it
 19 might -- you might need to spend some time looking
 20 through it. However, the actual process was clear.
 21 There was a flowchart which people could easily follow.
 22 Q. If we can look now to a meeting that happened
 23 then on 16 September, so this was a panel meeting that
 24 happened shortly after your interview with the RCPCH, so
 25 at this stage you are aware of the number of deaths on

45

1 Q. Yes. Designated rep, you are quite right.
 2 On the following page, if we can go then to page 2
 3 just to see what was discussed, because at that under
 4 review of children's cases, the second action point
 5 there is that you closed a case there and that's
 6 relations to Child I?
 7 A. Mm-hm.
 8 Q. And it says the child case referred to once
 9 the College report is presented by Dr Mittal?
 10 A. (Nods)
 11 Q. Was it unusual that a case was being closed
 12 when the RCPCH report hadn't been received?
 13 A. No, it would -- normally we wouldn't close
 14 cases until absolutely everything was received.
 15 Q. Right.
 16 A. And actually what we would do if we didn't
 17 think we had everything, we would refer back and get
 18 that information.
 19 Q. You weren't at this meeting?
 20 A. No.
 21 Q. So we have to ask other people about that.
 22 But it also then says action item to be added to
 23 the November meeting, subsequent meeting to consider
 24 that unexpected deaths in hospitals should be referred
 25 for RR meeting, so Rapid Response Meetings?

47

1 the neonatal unit, you are aware that the RCPCH are
 2 conducting a review and you have had this discussion
 3 with them?
 4 A. (Nods)
 5 Q. Now, that's INQ00178115.
 6 Now, in fact, Ms Dodd, this was -- we will see the
 7 attendance log -- a meeting that in fact you didn't
 8 attend, you were absent for this meeting. But I just
 9 want to look, so we see your name there a few lines down
 10 and we can see that you were absent at that meeting, if
 11 one works along.
 12 But this was chaired by Hayley Frame, we can see
 13 the other attendees where there is an R next to a name
 14 so for example Nigel Wenham is there with an "R". Does
 15 that mean they attended remotely or does R mean
 16 something else?
 17 A. No, we wouldn't have anybody attending
 18 remotely there. He might have been a representative for
 19 somebody else.
 20 Q. R means they --
 21 A. He may have been representing Serena Kennedy.
 22 Q. So "R" means you were there but you were
 23 representing someone else?
 24 A. I think some of the minutes do actually
 25 document what those abbreviations stand for.

46

1 A. Mm-hm.
 2 Q. Do you think that action came up because the
 3 RCPCH had been asking you about whether -- whether the
 4 SUDiC system had been followed, whether there were Rapid
 5 Response or SUDiC protocols being followed, do you think
 6 you referred that to the panel?
 7 A. It -- it may have been that or it may have
 8 been that Dr Mittal actually highlighted that -- the
 9 same sort of issue. I can't -- can't comment on which
 10 one it was, but I would assume it was either of those,
 11 yes.
 12 Q. If we can then go to a panel meeting that you
 13 were at and this is the one you have referred to
 14 a number of times, the one in March, so that's
 15 INQ0012008. So just to situate that in the timeframe,
 16 this clearly is quite a few months after the RCPCH have
 17 interviewed you?
 18 A. (Nods)
 19 Q. We see in terms of attendees we have got
 20 Hayley Frame who's chairing it, you are attending, we
 21 have -- I can't see now but, yes, Dr Mittal, and
 22 Nigel Wenham who are all at this meeting and if we can
 23 then turn to page 3.
 24 We see there that at this point, in March, it does
 25 seem that there is a concern about the trends. It says:

48

1 "The meeting discussed in depth the death, the
2 geographical area the children lived and the CDOP
3 processes and what could be done within the CDOP process
4 to ensure that trends can be or should be identified by
5 the Pan Cheshire panel."

6 So I think it's at this meeting, is it, that they
7 are recognising that the trends hadn't been picked up?

8 **A.** Yes.

9 **Q.** They make the point that the panel itself
10 wouldn't have been seized of this but as we have
11 discussed, there was an awareness of the number but the
12 panel would only have been discussing the deaths within
13 their areas.

14 It said going down:

15 "... Gill Frame asked can the CDOP be improved,
16 suggested this Form A could be amended, a place of
17 residence as well as a place of death would be
18 collated."

19 But in fact all the Form A material was already
20 being collated by you, wasn't it, so although it was
21 being pushed out to other areas, the Form A material --

22 **A.** We did have a log of them, yes.

23 **Q.** It goes on to say so they discussed the trends
24 and the fact they hadn't been identified.

25 At that meeting, did anybody raise the issue of

49

1 received, which didn't ever indicate that there was
2 a concern and only indicated that the babies that we
3 were informed about were very sick.

4 **Q.** Then looking, looking a bit further down,
5 because there's -- one concern is -- is the trend that's
6 clearly was discussed, or the failure to spot the trend
7 and then it talks about the SUDI, Sudden Unexpected
8 Death in Infancy and Childhood, it says:

9 "The panel discussed SUDI deaths within hospital
10 and whether it was felt that deaths were not always
11 treated with the same concern. If there was a concern
12 over the death a SUDI protocol could be followed."

13 I mean, it's not whether there was a concern, it's
14 when it was unexpected, the SUDI protocol?

15 **A.** It should have been followed, absolutely.

16 **Q.** It seems to be saying there that there was
17 a concern that that wasn't happening, is that your
18 recollection of the meeting?

19 **A.** Yes, that's right.

20 **Q.** Knowing that the SUDI protocol hadn't been
21 followed, did that cause anyone to think: we very much
22 need to look at this pattern because if that process
23 hasn't been followed, the checks and balances that
24 should follow an unexpected death are absent?

25 **A.** I -- I think at the time we were concerned

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1 Letby?

2 **A.** No.

3 **Q.** At this point, were you aware of allegations
4 or concerns about Nurse Letby?

5 **A.** I wasn't aware about the allegations about
6 Lucy Letby for quite some time. In fact, it was when
7 the media were at the hospital, that was the first time
8 I heard her name ever mentioned.

9 **Q.** So the first time you heard the name was after
10 the police were involved?

11 **A.** Yes.

12 **Q.** Did anyone discuss at this meeting -- we have
13 seen who were the attendees, did anyone discuss concerns
14 that a nurse or a healthcare professional might be
15 involved?

16 **A.** No.

17 **Q.** Having spotted at this stage, we have spoken
18 about your awareness earlier, but in terms of a panel
19 discussion at this stage discussing a trend, and we have
20 talked about the training you had had in relation to
21 Beverley Allitt, did anyone say: one of the areas we
22 should look at is whether a healthcare professional
23 might be involved?

24 **A.** No, they didn't. And I -- I think that was as
25 I say probably borne out of the information that we

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1 that the SUDI protocol wasn't followed because of lack of
2 knowledge and lack of education primarily and it was
3 after that that we did do some training around use of
4 the SUDI protocol.

5 I don't know why the SUDI protocol wasn't followed
6 because I would have thought that the paediatricians who
7 were -- who were, you know, certifying a death or
8 whatever it would be classed as should have spoken to
9 Dr Mittal because he was the -- the designated doctor
10 for safeguarding and child deaths and so he was the one
11 who potentially could have said: you need to do a -- you
12 need to follow the SUDI protocol and have a Rapid
13 Response Meeting.

14 **Q.** Was it any part of your role if you saw the
15 word "unexpected" or "unexplained" death, was it any
16 part of your role to check whether SUDI processes were
17 followed or not?

18 **A.** I would have spoken to Dr Mittal about that.
19 There was some -- some areas in their SUDI protocols
20 actually have a clause that say something around if
21 a child dies in hospital and they have previously been
22 unwell, that you may not need to impose the SUDI
23 protocol but in Cheshire West that wasn't the case. Our
24 SUDI protocol, the LSCB SUDI protocol in Pan Cheshire
25 did specify that an unexpected death in hospital should

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1 be -- should be followed, you should follow the SUDiC
2 protocol.

3 **Q.** So although you weren't reviewing the Form Bs
4 for the content, so to speak, as opposed to whether they
5 were completed if you saw that alerted you to unexpected
6 or unexplained you would have said?

7 **A.** I would have said to Dr Mittal what's -- you
8 know, do we need to have a Rapid Review Meeting for this
9 baby? You would have done without question. We had
10 done that before. There was -- there were times where
11 there was some confusion around unexpected or an
12 unexpected death, not especially for the neonatal unit
13 but just talking generally and we would discuss it and
14 we would have, you know, that kind of dialogue between
15 professionals and certainly it wasn't something that
16 wasn't discussed generally.

17 **Q.** Do you recall raising whether SUDiC had been
18 properly followed in relation to any of the indictment
19 babies, any of the babies' forms we have looked through?

20 **A.** I think at that meeting we probably had quite
21 a long discussion around this. I mean, it doesn't
22 indicate how long the time is that this discussion went
23 on for, but I suspect that we would have actually said
24 what did the Form As say.

25 **Q.** Because at that point, the realisation had
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1 initiated here. Do you know why that was?

2 **A.** No. I can, I -- I -- I don't know why that
3 would be. I can only assume that at the time the
4 paediatrician who certified the death must have made no
5 indication that it was completely unexpected.

6 It would appear just reading that that maybe they
7 had put on the Form A that the child was unwell prior to
8 that, not -- not expected to die.

9 **Q.** But having just had a panel discussion that
10 SUDiC wasn't being followed, having come to a conclusion
11 that it wasn't, wasn't that the point to say: we need to
12 now refer it?

13 **A.** Yes, you would think that -- that we should
14 review that back, we absolutely should have done.

15 **Q.** And if we can just go on just to complete the
16 picture to INQ 0001944, so this is the -- we look
17 finally at Form C, so this is the end of A. So we had
18 Form B where the information was sent and there was
19 obviously a long -- Child A was one of the cases where
20 there was a long pause before you came to consider it,
21 you were considering it now it was considered on
22 24 March and we see case summary there and that in fact
23 is just in fact copy pasted, it's from the Form B, it's
24 the summary from Form B.

25 If we could go then to page 3, we see "Panel
55

1 occurred to the Child Death Overview Panel, had it,
2 that --

3 **A.** Something was going.

4 **Q.** -- their process to spot patterns had failed?

5 **A.** It -- it had and actually even I -- I don't
6 know even if we would have sent every single Form A to
7 Pan-Cheshire, I don't know whether the trend would have
8 been noticed from a little while because of the
9 timeframe of child death reviews. It's a difficult
10 question to answer that.

11 **Q.** Let's just follow through what happened to
12 Child A because as well as these concerns about the
13 trend and about the SUDiC process not being followed,
14 this meeting actually looked at Child A because by the
15 time -- this time the other investigations, the
16 Coroner's process had ended.

17 So if we could go to page 11, we have the short
18 summary of the cases that were considered and we have
19 got Child A, so page 10, there and we see cause of death
20 at the top: "unascertained" and at the bottom:

21 "Form C completed. Case closed. Unexpected
22 death."

23 So there's an acknowledgement there by the panel
24 having considered it's unascertained and unexpected and
25 yet there was no SUDiC process for A and neither was one
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1 discussion". The case had been delayed coming to panel,
2 part of the neonatal review at the Countess of Chester.
3 However, the outcome of the review did not find any
4 issues with the death. The Coroner has given a verdict
5 of unascertained and therefore the panel agreed the case
6 could be closed.

7 Again, this was not ringing alarm bells at this
8 stage?

9 **A.** I think potentially it may not have running
10 alarm bells at that time. I mean, it's a difficult
11 thing to look back but this will have been quite a long
12 discussion. The -- the cases will have been presented
13 by a paediatrician. The way that the panels worked was
14 that if it was a neonatal death, for example, it would
15 be one of the paediatricians who presented the case to
16 panel and went through the Form As and the Form Bs and
17 they will have -- my guess now is that some of the
18 information from the Countess review would have also
19 been available at that time and I suspect that the
20 reason we didn't go back with that case to question the
21 unexpected death was because it had been through that
22 review process. And as it clearly says on here that
23 they didn't find any issues with the death and so we
24 have clearly concurred with them having looked at the
25 Form As and the Form Bs with the information that was
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1 available at that time.

2 **Q.** If we could just go on to page 5 then which is
3 the final page of that form, we see how the Child Death
4 Overview classified this death because -- and clearly
5 the categorisation was important because that's also
6 part of spotting patterns --

7 **A.** (Nods)

8 **Q.** -- to get the correct classifications and we
9 see there that it has been classified as a perinatal
10 neonatal Event 8?

11 **A.** And that would have --

12 **Q.** Why was it not 10, sudden unexpected,
13 unexplained death?

14 **A.** That will have been because of the information
15 that we had received. So if the information we had
16 received on the Form A and Form Bs had not said "Sudden
17 Unexpected Death", then that's not how it would have
18 been -- and the actual CDOP had to categorise the death
19 as the highest category that it was at the time.

20 **Q.** Well, we don't need to flick back, but the
21 review we have just looked at --

22 **A.** I know it does actually say "unexpected
23 death".

24 **Q.** Unascertained and unexpected?

25 **A.** I don't -- I can't answer why at that point as

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1 care, with everybody, usually within 48 hours of the
2 death. So that doesn't happen after the CDOP panel.
3 Because the CDOP panel meeting might be -- it could even
4 be a year, it could be a long time, especially if there
5 is going to be an Inquest, it could be a very long time
6 after death.

7 **Q.** So the situation is, isn't it, Ms Dodd, that
8 the CDOP panel at no point during this process either
9 spotted a pattern or referred any of these the deaths
10 that they were specifically considering Child A or
11 Child I to the SUDIc process?

12 **A.** They wouldn't have done it at that point
13 because the SUDIc process should have been implemented
14 as soon as the child died. So doing it that far down
15 the line is, is probably -- it may still be valuable,
16 actually. When you think about it like that, it may
17 still be valuable, but it's --

18 **Q.** Well, it may be valuable but at this point,
19 the police hadn't become involved?

20 **A.** No and actually -- so I guess the police are
21 there at the SUDIc -- at the CDOP panel meetings, the
22 police are aware of -- of those deaths. It is
23 a multi-agency meeting which is discussed in
24 a multi-agency, a multi-professional way. So it's not
25 down to one person to say what's happened, it's down to

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1 a panel of 12, 15 people we came up with that. I --

2 I can't answer that.

3 The only thing I can think is that it was discussed
4 in detail, it would have been presented by
5 a paediatrician, we would have looked at the
6 Royal College information as well, we would have
7 scrutinised the Form As and the Form Bs and that would
8 have been the reason for the categorisation.

9 But I understand what you are saying. And
10 I understand that potentially it could have been 10.

11 I think that the guidance for categorisation comes with
12 whether is highest. So I assume that at the time having
13 reviewed all the information, that was what we
14 categorised it as because it was the highest category.

15 **Q.** Of course the category is significant because
16 if it's been identified as a SUDIc, then there was the
17 SUDIc process, which would have potentially involved the
18 police.

19 **A.** Yes.

20 **Q.** So --

21 **A.** But the SUDIc process should have been long
22 before the CDOP panel, it would not have been
23 afterwards. The SUDIc process should actually be
24 implemented at the time of death and that child death
25 reviewed at a joint meeting with the police, with social

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1 that whole group of people.

2 **MS BROWN:** Yes, I have no further questions.

3 **LADY JUSTICE THIRLWALL:** Are there any other
4 questions?

5 **MS BROWN:** I believe there are no questions from
6 the Core Participants.

7 Questions by LADY JUSTICE THIRLWALL

8 **LADY JUSTICE THIRLWALL:** No, very well. There was
9 just one thing.

10 Just one question, if I may, Ms Dodd, and it was
11 going back to your discussions with Dr Mittal quite
12 early on when you were at sort of three or four deaths
13 and you say that "we may have discussed that there were
14 three or four deaths", but I just wondered: do you have
15 any memory of what you would have been discussing and
16 why you would have even been discussing it?

17 **A.** I think -- well, I -- we did work very closely
18 together.

19 **LADY JUSTICE THIRLWALL:** Yes.

20 **A.** And obviously we would be meeting for the CDOP
21 panel meetings and within the hospital -- the hospital's
22 small.

23 **LADY JUSTICE THIRLWALL:** Yes.

24 **A.** And, you know, any child death is devastating
25 but actually to have three or four on our neonatal

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1 unit -- well, I say "our" neonatal unit, it's not mine,
 2 generically speaking. It would be tragic.
 3 And so I would probably say to him: oh you know,
 4 Rajiv, what's happening? You know, it's really sad, you
 5 know another -- another baby has died and that would
 6 probably be the context of the conversation. It
 7 wouldn't be a scrutiny from my part at that point.
 8 **LADY JUSTICE THIRLWALL:** No.
 9 **A.** I think it would probably just be that we are
 10 acknowledging that we have got some very sick babies and
 11 it's tragic that we have lost another one.
 12 **LADY JUSTICE THIRLWALL:** Just stepping back now and
 13 doing the best that you can, I appreciate the looking
 14 back is always very difficult and putting yourself back.
 15 But you mentioned knowing about Beverley Allitt and the
 16 recommendation of the Clothier Inquiry?
 17 **A.** Mm-hm.
 18 **LADY JUSTICE THIRLWALL:** Have you ever been in
 19 a situation where it actually has come into your mind
 20 that maybe something's going on?
 21 **A.** In my whole nursing career, I -- I don't think
 22 so. I have occasionally worked with people where I have
 23 thought their competence could be improved.
 24 **LADY JUSTICE THIRLWALL:** Sure, yes.
 25 **A.** And may have discussed that with my manager or
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1 **LADY JUSTICE THIRLWALL:** All right. That is very
 2 helpful.
 3 **A.** Yes, I can't think -- as I say, I would --
 4 there might be some competence issue, there might be
 5 something that would alert me to an issue with
 6 a practitioner that I might actually go to my manager or
 7 go to their manager and raise that, but I have never,
 8 ever thought that somebody is doing something
 9 unthinkable in an area that might have been working at
 10 that particular time.
 11 **LADY JUSTICE THIRLWALL:** All right. Thank you very
 12 much indeed, Ms Dodd.
 13 Do you have any other questions?
 14 **MS BROWN:** No.
 15 **LADY JUSTICE THIRLWALL:** No. Well, then I am happy
 16 to say, firstly, that we will take the break and come
 17 back at 25 to 12 and, secondly, that you are -- thank
 18 you very much for coming to give your evidence and you
 19 are free to go.
 20 **A.** Thank you.
 21 (11.18 am)
 22 (A short break)
 23 (11.35 am)
 24 **LADY JUSTICE THIRLWALL:** Mr De La Poer.
 25 **MR DE LA POER:** My Lady, our next witness is
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1 their supervisor. Even at the time of this -- of this
 2 time, I don't think at the time we ever thought that
 3 anybody could be doing something like that and --
 4 **LADY JUSTICE THIRLWALL:** No, it is rather why I was
 5 asking if it ever occurred to you.
 6 **A.** I think really that was also sort of supported
 7 by the fact that the information we received didn't
 8 indicate that there were any concerns. So whilst we had
 9 a lot of neonatal deaths, none of the information that
 10 we immediately received or we immediately had to hand
 11 gave us any indication that there was anything wrong and
 12 certainly nobody ever spoke about it, nobody ever said.
 13 **LADY JUSTICE THIRLWALL:** You mentioned that and
 14 I absolutely understand --
 15 **A.** Yes.
 16 **LADY JUSTICE THIRLWALL:** -- what you say about that
 17 I was just wondering if there were any circumstances in
 18 which you ever thought the thing that may be
 19 unthinkable.
 20 **A.** I have -- I have been aware of it but I have
 21 never thought about that in my -- there's never been
 22 a situation in my career where I have been seriously
 23 worried about a practitioner --
 24 **LADY JUSTICE THIRLWALL:** Yes.
 25 **A.** -- who may be causing harm.
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1 Ms Hayley Frame and I wonder if she might come forward,
 2 please.
 3 **MS HAYLEY FRAME (sworn)**
 4 Questions by MR DE LA POER
 5 **LADY JUSTICE THIRLWALL:** Thank you very much, do
 6 sit down.
 7 **MR DE LA POER:** Please could you give us your full
 8 name?
 9 **A.** Hayley Frame.
 10 **Q.** Ms Frame, is it right that you provided to the
 11 Inquiry a witness statement dated 30 June of this year?
 12 **A.** Yes.
 13 **Q.** Is the content of that witness statement true
 14 to the best of your knowledge and belief?
 15 **A.** Yes.
 16 **Q.** By way of your background, did you qualify as
 17 a social worker in 1995?
 18 **A.** That's true.
 19 **Q.** Between 1995 and 2008, did you work in local
 20 authority children's social care?
 21 **A.** Yes.
 22 **Q.** Were you predominantly working in child
 23 protection or safeguarding?
 24 **A.** Yes.
 25 **Q.** Between 2008 to 2011, were you the child death
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1 manager for Nottingham City Local Safeguarding Children
2 Board?

3 **A.** I was.

4 **Q.** As part of that role, did you develop the
5 Child Death Review process in that area?

6 **A.** Yes.

7 **Q.** Pausing there for a moment. In that role, how
8 did you find the cross-boundary working, by which I mean
9 the areas surrounding that and the liaison between
10 theirs and yours?

11 **A.** Nottingham City is a unitary authority and
12 then in terms of the cross-border, cross-authority it's
13 with Nottinghamshire County Council, so the two councils
14 work very closely together across the whole safeguarding
15 agenda, they have joint safeguarding procedures.

16 When the requirement in 2008 was made for there to
17 be the Child Death Review process, it was agreed that
18 there would need to be very close working between
19 Nottingham City and Nottinghamshire County Council
20 because most of the deaths would have occurred in the
21 city because that's where the hospital was, the larger
22 teaching hospital.

23 So the -- all of the procedures were agreed
24 jointly. Even deaths that occurred outside of the
25 Nottingham City area would be referred into the

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1 I went to interview for the independent chair role.

2 I was also at that period of time providing expert
3 witness assessments in Family Courts. So I suppose the
4 point that I am -- I am stressing is that the
5 independent chair role was one of many roles that I had
6 during that period of time. It wasn't a full time job,
7 it was chairing of meetings.

8 **Q.** How many hours per week or per month were you
9 spending as the independent chair of the Pan-Cheshire
10 CDOP?

11 **A.** When I first was recruited to that role there
12 was a very large backlog of child deaths that hadn't
13 been through the process, the CDOP process, going back
14 years. So it was agreed that we would meet, it was
15 quarterly was the frequency of the meetings, but it was
16 agreed that we would meet every other month to try and
17 clear some of the backlog.

18 **Q.** So you have a meeting every other month.
19 Outside of that meeting, how much time were you devoting
20 to it, did you have an allocation of time or was it as
21 the job required?

22 **A.** As the job required. It was mainly, you know
23 agreeing agenda setting, signing off of minutes, any
24 actions that arose from the meeting that were assigned
25 to me.

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1 Nottingham City CDOP and we met jointly as

2 a cross-authority CDOP twice yearly. We also looked at
3 annual Thematic Reviews of neonatal deaths.

4 **Q.** In 2011, did you begin work as an independent
5 Consultant?

6 **A.** Yes, I was self-employed for 11 years.

7 **Q.** As an independent Consultant, were you
8 appointed to be the independent chair of the
9 Pan-Cheshire Child Death Oversight Panel in 2015?

10 **A.** Yes.

11 **Q.** What you say in your witness statement was
12 that your experience in Nottingham was key to that
13 appointment?

14 **A.** Yes, and when I became self-employed in 2011,
15 the bulk of my work that I was completing during that
16 period of time was I was the independent reviewer for
17 serious case reviews, domestic homicide reviews and
18 safeguarding adult reviews and I was also the
19 independent reviewer for drug-related deaths in
20 Nottingham City.

21 So it wasn't just around the child death manager
22 post that I had previously, it was in terms of my work
23 in the reviewing of death and learning lessons and those
24 statutory review processes.

25 So that -- that was my experience that I took when

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1 **Q.** Presumably scrutinising materials before
2 a meeting took place?

3 **A.** Yes.

4 **Q.** Are you able to give us any estimate of the
5 approximate number of hours outside of meetings that you
6 were spending on a weekly or monthly basis?

7 **A.** A day a month would probably be a fair
8 estimate.

9 **Q.** You have told us about the backlog and we will
10 come back to that in a moment. But bearing in mind what
11 you have reported to be a very positive experience in
12 Nottingham about the cross-border cross-boundary working
13 relationships, how did you find the Pan-Cheshire CDOP
14 cross-boundary cross-border working relationships?

15 **A.** Well, I suppose by virtue of the fact it was
16 the Pan-Cheshire CDOP so that was four LSCB areas coming
17 together, that was to recognise the fact that in
18 isolation the numbers of Child deaths would be so small
19 that it would be very difficult to identify any patterns
20 and trends from such a small cohort and also a number of
21 the statutory services worked across those boundary
22 areas so that is why the Pan Cheshire came together from
23 the four LSCB areas.

24 In terms of liaison outside of that, there was the
25 North West -- I'm sorry, my memory escapes me, I am sure

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1 I refer to it in my statement. I never attended the
 2 meeting which is why I am probably not remembering.
 3 **Q.** North West regional?
 4 **A.** Yes, thank you. So that -- that was in place.
 5 We didn't -- at that point the requirements under
 6 Working Together to Safeguard Children had changed so
 7 whereas when I worked in Nottingham there was
 8 an expectation that you would be -- the CDOP would be
 9 notified of all deaths in that area, regardless of home
 10 address. That changed. So in the Pan-Cheshire CDOP we
 11 were only notified of deaths of children whose parents
 12 were resident in that area. So any child that would
 13 have been outside of the CDOP -- Pan-Cheshire CDOP
 14 boundary we wouldn't have been notified of. So there
 15 was minimal liaison.
 16 **Q.** Well, bearing in mind that change, doesn't
 17 that change reinforce the need for very strong
 18 communication to surrounding areas?
 19 **A.** Yes.
 20 **Q.** Was that something that as chair, you focused
 21 upon or tried to develop in any way over the time that
 22 you were chair?
 23 **A.** No. And I -- the reason for that was that
 24 when I was appointed as the independent chair it was
 25 because there was a significant amount of work to do to

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1 So there was a lot of work to do to correct those
 2 processes internally before thinking wider than that.
 3 **Q.** When you say the Rapid Review process wasn't
 4 being instituted, was that across all sudden unexpected
 5 child deaths, so in the community, in hospital or were
 6 there particular pockets or areas that didn't seem to be
 7 triggering that process?
 8 **A.** It was the issue around home visits. So the
 9 Rapid Response process is that the -- a relevant health
 10 professional, preferably a Consultant paediatrician,
 11 would do a joint visit with the police following an
 12 unexpected death.
 13 **Q.** If I can just stop you there. You will
 14 appreciate the Inquiry's particular focus is upon
 15 hospitals?
 16 **A.** Yes.
 17 **Q.** So I hear what you say about where -- where
 18 that identified problem area was. Can I invite you to
 19 consider whether the issue about SUDiC and hospital
 20 deaths was that an issue that you perceived as existing
 21 when you took over as chair?
 22 **A.** No, not when I took over, no, obviously there
 23 were discussions in relation to that into some of the
 24 panels that I chaired but no, not at the point that
 25 I took over.

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1 get the CDOP to be fit for purpose in many ways. That
 2 was around -- a lot of that was around the backlog.
 3 The child death co-ordinator had only just started
 4 in post, there was a lot of work that needed to be done
 5 in terms of Terms of Reference, attendance, that --
 6 there were certain things that the CDOP or the Child
 7 Death Review process didn't do. So, for example, it was
 8 well known from the outset that they weren't compliant
 9 in terms of Rapid Response arrangements at that point.
 10 **Q.** Just pause there. Is that under the SUDiC
 11 process when you say Rapid Response?
 12 **A.** Yes, yes, I think -- I think the terminologies
 13 changed. I haven't worked in the field of child deaths
 14 since 2017 so I think it's like a joint response, Isn't
 15 it.
 16 **Q.** It is the Joint Agency Response, JAR?
 17 **A.** Yes. Back then it was called a Rapid
 18 Response.
 19 The profile of the CDOP the quality of the
 20 information being submitted on the Form Bs, there was
 21 a lot of work that needed to be done to just try and get
 22 it up to speed. The CDOP didn't review deaths of babies
 23 less than 23 weeks, even if they had taken a breath,
 24 which again wasn't compliant with the statutory
 25 guidance.

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1 **Q.** What was your understanding about whether or
 2 not there was a need for a Rapid Response Meeting under
 3 the SUDiC protocol if a baby was born in hospital and
 4 died on the neonatal unit?
 5 **A.** If death was unexpected, then the same process
 6 applies. We had had these discussions in my previous
 7 role in Nottingham and we agreed that it would need to
 8 be looked at on a case-by-case basis and be
 9 a proportionate response, but that the process would
 10 still be followed nonetheless.
 11 **Q.** So would that mean that as a very minimum that
 12 for every Sudden and Unexpected Death the designated
 13 doctor would be notified of that?
 14 **A.** Yes, yes.
 15 **Q.** And is it at that point that you were
 16 envisaging that there would be a discussion about
 17 whether or not that Rapid Response Meeting involving the
 18 other agencies should occur?
 19 **A.** Yes.
 20 **Q.** Now, we have already had explained to us the
 21 purpose of the Child Death Overview Panel. Can I just
 22 invite you to consider this in summary: was one of its
 23 main functions to look for trends or patterns?
 24 **A.** Yes.
 25 **Q.** In the two years that you were chair, were

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1 there any -- and you don't need to list them, but were
 2 there any trends or patterns identified by the Child
 3 Death Overview Panel?
 4 **A.** Not specifically in relation to neonatal
 5 deaths, no. We had a campaign around safe sleeping, we
 6 had lots of discussions around maternal smoking and
 7 obesity, so there -- definitely we were identifying some
 8 learning. But there wasn't -- it was very difficult in
 9 terms of like identifying trends because we were dealing
 10 with a backlog as well so we weren't reviewing the
 11 deaths in a timely way.

12 So that obviously skews the data as well.

13 **Q.** The fact that you were dealing with that
 14 backlog and the confusion that that might lead to or the
 15 uncertainty that might do, did that require quite
 16 a systematic approach where you started to populate
 17 things on a year-by-year basis so that you could make
 18 sure that you were getting a clear view of deaths in
 19 context?

20 **A.** I had to do a quarterly report, a quarterly
 21 chair's report which included the performance data.

22 **Q.** But if I can just stop you there. I am not
 23 just asking about reporting on the deaths that you were
 24 considering in that quarter but about putting those
 25 deaths into their proper context so that if they had

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1 was another thing that I brought into place.

2 **Q.** In terms of the drivers that you have spoken
 3 about, to clear the backlog?

4 **A.** Yes.

5 **Q.** Just looking back on it reflectively, do you
 6 think there's any possibility that during the period
 7 that you were chair, there was perhaps too much focus on
 8 clearing the backlog so you could have a clean start and
 9 do it properly as you would want to as opposed to
 10 perhaps being as systematic as should have been the case
 11 with each of the backlog?

12 **A.** I believe that we still reviewed each death
 13 with the amount of attention that it needed, based on
 14 the information that CDOP was provided with. So it
 15 wasn't like it was rushed, hence why we increased the
 16 frequency of meetings.

17 But I suppose it did mean that the number of
 18 neonatal deaths was higher that we were reviewing as
 19 a CDOP because neonatal deaths fall into the greater
 20 category, the largest category anyway and so that would
 21 have felt like we were reviewing a lot of neonatal
 22 deaths and one of the things -- I am sure it's in one of
 23 the annual reports that I wrote -- talking about doing
 24 a Thematic Review, learning from what had happened in my
 25 previous roles in Nottingham and we also looked at the

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1 been -- taken 18 months to come through, that you were
 2 looking back to that earlier period to consider whether
 3 that death, at that time, formed part of a pattern; do
 4 you see?

5 **A.** Yes, I do.

6 **Q.** Do you see what I am saying?

7 **A.** I do.

8 **Q.** Yes, and did that process occur?

9 **A.** No, it didn't.

10 **Q.** Bearing in mind the obvious challenge of
 11 clearing a backlog, do you think on reflection that
 12 should have been something that was occurring as
 13 an additional part of the process of clearing the
 14 backlog?

15 **A.** Yes, I think that the driver was to just try
 16 and at least be -- there are statutory timescales in
 17 terms of the length of time it should take to review
 18 a death, and some of these deaths were like two years or
 19 more, so that the driver was to really try and get on
 20 top of it so that we could concentrate on the new
 21 notifications and complete those in a timely way.

22 There was, there wasn't -- there was no -- there
 23 wasn't an action log in place, for example. So when
 24 a child death was reviewed and there might be actions
 25 there was no mechanism to actually track those. So that

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1 modifiable factors of -- I can't remember which year it
 2 was, it might have been 13/14, we looked at all of the
 3 modifiable factors in terms of the actions relating to
 4 those to see what -- so the "so what" question: what
 5 happened? We made these recommendations as a CDOP and
 6 what action was taken to try and evidence the learning.

7 **Q.** Bearing in mind that the panel's function was
 8 to look for trends or patterns --

9 **A.** Mm-hm.

10 **Q.** -- was it necessary for concerns to be raised
 11 as part of the forms being filled in or did the panel
 12 also have a function to stand back and say: well, there
 13 are perhaps too many deaths in this area compared to our
 14 expectation, so in other words the raw data itself
 15 rather than the detail of each case, was that something
 16 the panel was concerned with?

17 **A.** The panel received that -- that data as part
 18 of my quarterly reports, so that had -- it had that data
 19 there in terms of the number of deaths reviewed. At no
 20 point were there any concerns raised in terms of
 21 clusters or -- or any patterns, no.

22 **Q.** But a cluster might be self-evident if you get
 23 a large number of deaths. Even if in the case of any
 24 given one of them, there is no specific concern raised,
 25 provided the panel is sighted on all of the deaths in

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1 that cluster, might that be something that the panel
 2 notices and says we have had a surprising number of
 3 deaths?
 4 **A.** Yes.
 5 **Q.** That in itself is something that we need to
 6 investigate?
 7 **A.** Yes, if they were notified of them all,
 8 absolutely.
 9 **Q.** So in other words you are not solely reliant
 10 upon people raising individual concerns, you do have
 11 a step back and look at the overall --
 12 **A.** Yes.
 13 **Q.** -- picture --
 14 **A.** Yes.
 15 **Q.** -- role.
 16 Now, a point you make a couple of times in your
 17 witness statement is that because of the way that the
 18 panel system was working at that time, not all of the
 19 deaths from the neonatal unit during the period we are
 20 focused on were deaths that the panel was scrutinising?
 21 **A.** Yes, that's right.
 22 **Q.** We know that in fact it is only Child A and
 23 Child I who were the subject of a panel meeting?
 24 **A.** Mm-hm.
 25 **Q.** The Inquiry has heard evidence from

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1 I didn't have, like, agency records, I haven't had
 2 anything to go back to. So I have been trying to think
 3 about this and obviously reading through the documents
 4 that I have been sent, because there was mention of the
 5 review when we were considering one of those two
 6 children because there was a discussion around that
 7 child being part of the cohort of children that were
 8 subject to the review. So that must have been the first
 9 time I knew about it, thinking about it.
 10 **Q.** So if I can just help you with that, that's
 11 a meeting that took place on 16 September and we are
 12 going to look at the detail of that meeting?
 13 **A.** Okay, so that must be the first mention so --
 14 I think. So that must have been when I first became
 15 aware that there was going to be a review. To be
 16 honest, I am just putting myself in my own shoes back
 17 then, given that more Thematic Reviews of neonatal
 18 deaths were seen as in a positive way because often with
 19 neonatal deaths, especially in cases of extreme
 20 prematurity, there hadn't any modifiable factors, there
 21 isn't huge amounts of learning, it's entirely due to
 22 a child's prematurity, so to look at them thematically
 23 in a larger cohort, and I think probably that is what
 24 I thought was happening at that stage.
 25 And then I became aware -- I think it was around

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1 Sharon Dodd this morning about the fact that all the
 2 Form As, regardless of whether or not the child
 3 ultimately was considered by the panel, passed through
 4 her hands, I think the exception being Child O and
 5 Child P, and that she kept a log or a tally.
 6 Now, her evidence was that she didn't tell you
 7 about that. Do you have any recollection at all about
 8 those Form As and any tally being kept or record?
 9 **A.** No.
 10 **Q.** Is that something that you should have been
 11 told about, do you think?
 12 **A.** I think it's difficult, isn't it, because
 13 there was no longer the statutory requirement for the
 14 CDOP that covers the area where a child died to be
 15 notified.
 16 I think if -- if the concern is that there's
 17 actually a spike, then absolutely, then the CDOP should
 18 have had that discussion and I should have been
 19 notified. But there wasn't -- there wasn't a framework
 20 for that information to be routinely passed to the CDOP.
 21 **Q.** In terms of your awareness of when there
 22 was -- that there had been an unexpected increase in the
 23 number of deaths on the Countess of Chester neonatal
 24 unit, when do you believe that was?
 25 **A.** Because I -- because I was self-employed

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1 the time that the report -- the report was going to be
 2 published because they had made recommendations in it
 3 for the CDOP, so there was email correspondence there
 4 before the meeting in March when we went through it,
 5 yes.
 6 **Q.** Again we will come to that. But we will add
 7 some detail around your answers there very shortly.
 8 Before we get to that stage of the chronology, I would
 9 just like to take you, please, to an interview that
 10 Ms Dodd conducted, or was the subject of, with the
 11 RCPCH?
 12 **A.** Okay.
 13 **Q.** You have seen these notes already as part of
 14 your preparation but we will bring them up, INQ0014605
 15 and we will go to page 21, please.
 16 Now, Ms Dodd has given her best recollection of
 17 what these notes may mean or what she says about them so
 18 I am not going to ask you to interpret them, just to
 19 treat them on their face.
 20 Firstly, we can see five lines down a reference
 21 I think to you, it is a misspelling but as chair of the
 22 CDOP and it would appear that Ms Dodd has suggested that
 23 you could be spoken to.
 24 Do you think that the RCPCH, knowing what you do
 25 now, should have spoken to you as the chair of the CDOP?

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1 **A.** Yes, and I think I would go further than that.
2 I think that the CDOP and the wider LSCB should have
3 been part of the Terms of Reference. It's -- the fact
4 that that review was done completely in isolation and
5 not in a wider partnership arrangement doesn't make
6 sense to me.

7 **Q.** Now, again, we have heard what Ms Dodd's
8 evidence is about this so I am not going to repeat that.
9 But "CDOP not worried", just treating that on its face.

10 At this point, right at the beginning of
11 September 2016, so before that meeting involving
12 Child I, was CDOP -- you, the chair of CDOP, aware of
13 the increase in mortality?

14 **A.** No. So I can only assume that's what that
15 means, "CDOP not worried". Well, we didn't know we had
16 anything to be worried about.

17 That -- that's my assumption. It's strange that --
18 the way it's set out, could talk to me, but then it
19 talks about "CDOP not worried" as though they are two
20 quite separate things. So I don't understand that but
21 that can be my only sort of assumption.

22 **Q.** All that you can say is that it is literally
23 right that CDOP wasn't worried but the reason for that
24 is you didn't know?

25 **A.** Yes.

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1 have expected to have had a discussion following that
2 with Ms Dodd so that she could tell you about the
3 discussion that she had had and the fact that CDOP had
4 come up?

5 **A.** Yes, and we may well have done. I just can't,
6 I can't recall that we did. I have not worked in the,
7 in the field of -- of Child Death Review since 2017 so
8 in many ways, you know, I -- I don't have the
9 recollection of whether we did or whether we didn't and
10 I don't have any agency records to go back to look to
11 see if we had that conversation. I don't remember
12 having a conversation with her.

13 **Q.** Because if a review is being conducted which
14 encompasses a number of deaths, would it not be quite
15 important for CDOP to know that so that there could be
16 a very clear understanding about whether any particular
17 death that has already passed through CDOP, whether that
18 was subject to the review at any future death that is
19 going to pass through?

20 **A.** Yes, because thinking about it, you know, we
21 perhaps should have shown more curiosity in terms of who
22 are the children that are subject to this review and we
23 didn't ask those questions.

24 Whether I think we should have done, it's difficult
25 with sort of hindsight bias, isn't it, because we didn't

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1 **Q.** Thank you very much indeed. We can take that
2 down.

3 Just casting your mind back, did you know that
4 Ms Dodd, who wasn't in fact interviewed in her capacity
5 as her role on CDOP, but in fact an internal --
6 a paediatric liaison role that she had.

7 **A.** Okay.

8 **Q.** Did you know that she had been interviewed by
9 the RCPCH?

10 **A.** I don't believe I did, no.

11 **Q.** Is that something that you should have been
12 told as CDOP chair, do you think?

13 **A.** Not necessarily. I suppose we were just
14 awaiting the findings of the report. We weren't
15 involved in the -- you know, the mechanisms of the
16 review. As I say, you know, now thinking about that we
17 perhaps should have been, but we weren't and there was
18 nothing, no one had raised that there was any concern.

19 So I suppose I didn't know that there was anything
20 that needed to be scrutinised any further.

21 **Q.** Now, once Ms Dodd had been interviewed and it
22 was plain that the RCPCH were there at the hospital
23 investigating or conducting a review which arose out of
24 an increase in the neonatal mortality rate, and it would
25 appear that there was some discussion of CDOP, would you

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1 know that there was any reason to ask those extra
2 questions. But looking back now it would have been,
3 yes, if we had would have been involved in the Terms of
4 Reference, if we knew the children, how many had come
5 through Pan Cheshire CDOP, how many had gone to other
6 CDOPs, then absolutely, that would have been helpful.

7 **Q.** We will look now at the meeting on
8 16 September, INQ00178115

9 Now, against your name for this meeting there is an
10 R which, if we go over the page, signifies designated
11 rep?

12 **A.** (Nods)

13 **Q.** Does that mean that you were representing
14 somebody else or somebody else was representing you?

15 **A.** Dr Mittal chaired in my absence, I wasn't
16 present.

17 **Q.** I think we can see that from the next line
18 just below.

19 The fact that you weren't there, would you still
20 have read the material ahead of the meeting?

21 **A.** Yes, and agreed the agenda.

22 **Q.** Agreed the agenda?

23 **A.** Mm-hm.

24 **Q.** Do you recall if you had any discussion with
25 Dr Mittal ahead of the meeting given that he was

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1 representing you?

2 **A.** I don't recall and I don't know why I wasn't
3 there, if it had been -- if it was due to sickness and,
4 you know, an urgent matter then probably not. But
5 sometimes I couldn't attend because I was due to give
6 evidence in court. So it -- I don't recall
7 a conversation with him.

8 **Q.** Did you have a responsibility following the
9 meeting even if you didn't attend to read the minutes
10 and to understand what had happened?

11 **A.** Yes.

12 **Q.** As chair if you were concerned about anything
13 that you saw on the minutes, would it be your place to
14 raise that and say: I just need to understand what
15 happened at the meeting because I don't agree with it or
16 I can't --

17 **A.** Yes.

18 **Q.** I can't fathom it?

19 **A.** Yes.

20 **Q.** Now, in section 3 on this first page, we can
21 see Child I's case was closed and:

22 "The child details to be sent to the Coroner for
23 review of case notes. The child case to be referred to
24 once the Royal College report is presented by
25 Dr Mittal."

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1 **Q.** I mean, did you understand the Coroner to have
2 an assurance role after a CDOP case was closed?

3 **A.** No. We were -- we had worked quite hard on
4 improving our relationships with the Coroner's office
5 and we had representation -- I wonder if we did at that
6 one. No -- yes, in attendance Christine Hurst. Without
7 being present I don't know if there was a conversation
8 between Dr Mittal and Christine about what the Coroner
9 could do to help, I don't know. But I am assuming it
10 would be for a review for assurance.

11 **Q.** What also seems clear from the face of the
12 minutes, and in fact we know, is that the College hadn't
13 issued its report which incorporated its consideration
14 of the period that Child I died during?

15 **A.** Mm-hm.

16 **Q.** Do you think that in fact it was inappropriate
17 to close Child I's case whilst there was still a review
18 that might shed some additional light which was ongoing?

19 **A.** Yes.

20 **Q.** Because as we have understood it, CDOP, as in
21 the panel meeting, represents the very end of the Child
22 Death Review process?

23 **A.** (Nods)

24 **Q.** And absolutely every investigation should have
25 taken place and been resolved insofar as it could be by

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1 Now, this case, as we will see on the Form C, was
2 closed at this meeting, effectively as I understand it,
3 meaning that the all of the data had been taken that
4 needed to be taken for the Form C and that could then be
5 entered on to the database for the pattern recognition;
6 is that right?

7 **A.** In part. And the reason I say that is because
8 there were actions. So those actions would have then
9 gone into the action log which was considered at every
10 meeting.

11 So the actions you would send to the Coroner for
12 review of the case notes, that would have led to an
13 action being logged on the action log. So although the
14 case was closed, that should have been ongoing.

15 **Q.** What would you expect to happen? If the
16 child's details were sent to the Coroner for review of
17 case notes, what in practice was that going to lead to?

18 **A.** I supposed -- just for assurance.

19 **Q.** So there was an expectation that the Coroner
20 would receive that child's notes from CDOP regardless of
21 whether they had otherwise seen anything about Child I's
22 case and review them and comment upon them?

23 **A.** I assume so. It's difficult for me to --
24 I wasn't party to that discussion. But I assume that's
25 what the thinking was.

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1 the time that the panel closes the case; is that right?

2 **A.** Yes, that's correct.

3 **Q.** So on the face of it, that isn't what happened
4 here.

5 Now, when you received these minutes, do you have
6 a recollection of noting that point and wondering about
7 it or having some curiosity about why a case has been
8 closed in circumstances where firstly the Coroner
9 appears to be looking at it, and the RCPCH still hasn't
10 provided its report?

11 **A.** I don't, I don't recall and I know that's not
12 particularly helpful but I absolutely don't. But that
13 -- that would have been of concern, that is of concern.
14 So I would have hoped that I would have queried that.
15 Without seeing the action log, I don't know what -- what
16 happened as a result of that.

17 But that would be unusual for the case to be closed
18 and maybe I was assured by the action log, I don't know.

19 **Q.** It's unusual and sitting there now, although
20 some time later, you don't have any recollection of
21 having followed this up. Do you think that suggests
22 that you probably didn't?

23 **A.** I -- I don't know. If I didn't then I should
24 have done.

25 **Q.** Page 5, please, we will see --

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1 **LADY JUSTICE THIRLWALL:** Have you finished with
2 this point, Mr De La Poer?

3 **MR DE LA POER:** Of course my Lady.

4 **LADY JUSTICE THIRLWALL:** Are you continuing with
5 the same point?

6 **MR DE LA POER:** No.

7 **LADY JUSTICE THIRLWALL:** I wonder if I might ask
8 something. I'm sorry, would you mind just putting that
9 page back up again? I just want to ask a question for
10 clarification.

11 It's slightly odd to say -- if you look at the
12 section 3 "Review of Children Cases", and then "3.
13 Action: case deferred" and then we have "Action: closed
14 case" rather than "case closed".

15 And are you there looking at or are they there
16 looking at a case which has been closed because it then
17 says "child's details to be sent to Coroner" etc, etc
18 and if we look further down "Action: closed",
19 a different child "the CCG to be contacted to ensure
20 that the RCA report" et cetera. Then the following one
21 "closed case" "The conclusion of the Inquest report to
22 be added to the Form C".

23 What's not clear to me, having looked at them all
24 while you are being asked about questions of the others,
25 is what's being described there, information that's

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1 **LADY JUSTICE THIRLWALL:** Just so I understand it,
2 although a case was closed, in all of these examples
3 further action was to be taken to complete the file in
4 some way or another?

5 **A.** Yes, there might still be actions, yes.

6 **LADY JUSTICE THIRLWALL:** Yes. Well, if
7 Mr De La Poer wants to explore that any further
8 obviously he will do, but that is sufficient for my
9 purposes, thank you.

10 **MR DE LA POER:** My Lady, I certainly had in mind to
11 ask Dr Mittal about that.

12 **LADY JUSTICE THIRLWALL:** Yes, I thought you might.
13 Yes.

14 **MR DE LA POER:** Page 5, please, we will look at
15 what is said about Child I. We can see a little more
16 detail about the Royal College. In fact it says in
17 terms:

18 "This child's death is subject to review at the
19 Countess by the Royal College."

20 So not just the period during which that child
21 died, but that child's death itself?

22 **A.** Mm-hm.

23 **Q.** Is that even greater cause for concern for you
24 looking at this that it would appear that there is
25 a direct investigation going on into that child's death

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1 going to be put into the files, where the cases have
2 already been closed or do you always go closed and then
3 add things to them?

4 **A.** No. I think it's -- it's the case was closed.
5 That was the --

6 **LADY JUSTICE THIRLWALL:** That was the action in
7 that meeting?

8 **A.** Yes, yes, close the case.

9 **LADY JUSTICE THIRLWALL:** So all of those cases --

10 **A.** Yes.

11 **LADY JUSTICE THIRLWALL:** -- the cases were closed
12 but with something else that has to be done?

13 **A.** So it might be where there was information
14 hadn't been put in the right form, so "the conclusion of
15 the Inquest report to be added to the Form C". So
16 that's obviously information that we had hadn't been
17 input to the Form C.

18 **LADY JUSTICE THIRLWALL:** But when was that going to
19 be done, after the case was closed or before the case
20 was closed?

21 **A.** Yes, so that would be what the CDOP
22 administrator/co-ordinator would do.

23 **LADY JUSTICE THIRLWALL:** Would have done.

24 **A.** In fact, yes, the actions -- those actions are
25 for her.

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1 in circumstances where simultaneously the panel is
2 closing the case?

3 **A.** I suppose there's two -- two parts to that,
4 isn't there? We didn't -- I didn't know as the Chair of
5 the panel and it wasn't discussed within panel, so my
6 assumption is that most panel members equally were
7 unaware that there was a concern.

8 So this child's death being subject to that review,
9 given that there wasn't a concern about the review,
10 probably meant that that didn't trigger any further
11 discussion or scrutiny.

12 However, the point is the same; that if a child's
13 death is being subject to a parallel process, a review,
14 then it shouldn't have been closed.

15 **Q.** We can see that there is an action which
16 includes an item for:

17 "The next panel meeting to discuss if unexpected
18 deaths in hospital should be considered for an RR
19 meetings, the child to be referred to once the
20 Royal College report is presented by Dr Mittal"?

21 **A.** Mm-hm.

22 **Q.** Now, you have told us that in your mind there
23 should always be an initiation of the SUDIc process --

24 **A.** Yes.

25 **Q.** -- in the event that the death is unexpected,

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1 even in a hospital. Does it surprise you that that
2 appears to need to be a subject for discussion as
3 opposed to: this is what the protocol is, we all just
4 need to get on with it?

5 **A.** I think seeing it in the context of even in
6 unexpected deaths, the Rapid Response -- in the
7 community, the Rapid Response process wasn't being
8 followed.

9 It just -- it just felt for me that there was so
10 much that wasn't in place that should have been in
11 place. You know, in other areas they will have a rota
12 of on-call paediatricians so in the event of a -- you
13 know, an unexpected death in the community or in
14 hospital, that person will be contacted out of hours.
15 That starts the process.

16 There was lots of discussions and a business case
17 put together with various different options for to be
18 taken to the CCG, as was, around how we were going to
19 meet that need within Pan-Cheshire because it was
20 a funding issue.

21 So there was so much that wasn't in place that
22 should have been and was in other areas. So I suppose
23 was I surprised that the Rapid Response process didn't
24 happen for unexpected deaths in hospital? Probably not,
25 because it wasn't happening robustly in the community

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1 face of it and item 10, do you agree, appears to fit
2 that?

3 **A.** Yes.

4 **Q.** Now, a point that Ms Dodd made and I seek your
5 help on, if you look right at the top it says:

6 "The classification is hierarchal. Where more than
7 one category could reasonably be applied, the highest up
8 the list should be marked."

9 **A.** Yes.

10 **Q.** What was your understanding of how this form
11 operated and how it was in a hierarchy and what was it
12 trying to get at by ranking these different descriptors?

13 **A.** Well, these were national descriptors and set
14 out in that order. So that would have been Department
15 of Health at the time, I suppose.

16 When you look at it, it reads almost -- you start
17 with what's potentially a safeguarding or a crime, don't
18 you? It's deliberate inflicted injury, abuse or
19 neglect. And then sort of go down in terms of moving
20 more into conditions relating to the child.

21 But if that was the case, if we were going from,
22 you know, conditions related to the child, chronic
23 medical conditions, cancer, up to trauma and inflicted,
24 you would think that sudden and unexpected, unexplained
25 death would be higher up, wouldn't you, because we don't

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1 either. Well one, that, that element of a home visit,
2 a joint home visit not being completed.

3 **Q.** Well, at all events it appears apparent from
4 this record that in the context of Child I's case there
5 is a discussion about the SUDIc protocol and we will
6 just briefly look at the Form C for Child I, INQ0001946.

7 We can see the start of the case summary has that
8 word "Sudden"?

9 **A.** Yes, yes.

10 **Q.** So on the face of it, a clue, would you agree,
11 that this child's death ought to have been the subject
12 of SUDIc?

13 **A.** Yes.

14 **Q.** If we look at page 3, we can see under the
15 issues identified the same terms which appear in the
16 summary there about the RRM.

17 Then finally if we go to page 5, I am just going to
18 ask you a question that Ms Dodd was asked about, this
19 tick box?

20 **A.** It's wrongly categorised.

21 **Q.** Well, exactly so.

22 Now I appreciate this isn't your meeting in the
23 sense that you weren't there, but we have seen that
24 there was plainly a discussion about RRM and sudden and
25 unexpected, we can see the word "sudden" appears on the

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1 know why that child's died? It is always at the bottom
2 and that doesn't really make a great deal of sense
3 looking at it now.

4 What Sharon said is right, absolutely, the highest
5 up the list should be marked but it's the wrong
6 category. It should be -- it should be 10.

7 **Q.** If one thinks about it in terms of the taking
8 a step back role that CDOP had, lots of sudden,
9 unexplained, unascertained deaths might be thought to be
10 a major red flag; do you agree?

11 **A.** If there were lots of them.

12 **Q.** If there were lots?

13 **A.** Yes.

14 **Q.** But if consistently, as you point out, you are
15 moving up the hierarchy because you might reasonably
16 describe it as one higher up, you are going to miss that
17 big picture because that -- that box 10 isn't going to
18 be ticked in necessarily every case it could be?

19 **A.** I suppose the other thing to remember, though,
20 is by this point, because it is at the conclusion of the
21 Child Death Review process, whether that was expected or
22 unexpected death, we should know the cause of death so
23 that's what this -- this -- this category is around.

24 So you may have an unexpected death but the process
25 itself, the Rapid Review process, has determined that it

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1 was due to infection or it was due to a chronic medical
 2 condition that people weren't aware of. So that -- that
 3 would be -- if you knew the cause you would then tick
 4 that box.

5 **Q.** Well --

6 **A.** You wouldn't because every unexpected death,
 7 the purpose of the process is to establish the cause.
 8 So that might not be the case, you wouldn't tick that
 9 box for every single unexpected death.

10 **Q.** If I can just pause you there. In Child I's
 11 case, at this time, there was a cause of death that was
 12 given, we have seen that in the form?

13 **A.** Extreme prematurity was part of it, I think,
 14 wasn't it?

15 **Q.** Yes?

16 **A.** Yes, so that would be why the panel will have
 17 lended themselves to 8.

18 **Q.** Thank you. We can take this down, we are
 19 going to move forward a few days to 26 September. And
 20 on this date, there was the Cheshire West Local
 21 Safeguarding Children's Board meeting and I believe you
 22 presented a draft CDOP annual report to that meeting,
 23 and I just want to ask you, please, about the
 24 circumstances before that meeting.

25 These minutes were produced presumably within

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1 **A.** I didn't know.

2 **Q.** I mean, had you known is that something that
 3 you would have included in the report?

4 **A.** Probably not. Only as much as I would -- we
 5 would need more information and the annual report is
 6 talking about the previous year's performance as opposed
 7 to any current.

8 **Q.** Well it's 2015 to 16, the sudden unexpected
 9 increase in the neonatal mortality rate began in
 10 June 2015, so will have fallen within the period for
 11 your draft annual report?

12 **A.** Had I known that then yes, it would have been
 13 included.

14 **Q.** Moving forward to 3 October. INQ0012781.
 15 Again we don't need to look at all of the detail of this
 16 because you have had an opportunity to refresh yourself
 17 and I would like it deal with it by way of summary.

18 We can see that Ms Eardley has sent an email to --
 19 presumably that is the CDOP general inbox that it's gone
 20 to? We don't see the whole of it there but --

21 **A.** (Nods)

22 **Q.** -- it's not with your name on it?

23 **A.** No, it's the inbox that Ann McKenzie had
 24 control over.

25 **Q.** And it is addressed to Ms McKenzie/you on the

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1 a relatively short period of time of 16 September, was
 2 that the process?

3 **A.** It -- it didn't take the administrator huge
 4 amounts of time to create the minutes, no.

5 **Q.** I suppose the question really comes down to
 6 this: would you have expected to have seen those minutes
 7 by the time you went to that safeguarding meeting?

8 **A.** What's the time difference between the two
 9 meetings?

10 **Q.** We have got 10 days.

11 **A.** Probably not.

12 **Q.** Probably not?

13 **A.** No.

14 **Q.** So does it follow from that that you don't
 15 think that you would necessarily have been aware of what
 16 was said at the meeting you didn't attend about the
 17 Royal College report?

18 **A.** Yes.

19 **Q.** In which case we can shortcut this. The draft
 20 report that you presented makes no mention --

21 **A.** No.

22 **Q.** -- of an increase in mortality. Is the
 23 explanation for that based on what you have just told us
 24 that you at that point, 26 September of 2016, didn't
 25 know?

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1 face of it?

2 **A.** Yes.

3 **Q.** And in that email, Ms Eardley points out that
 4 the RCPCH has been looking at the relatively high number
 5 of deaths during that period, June 15 to July 2016, and
 6 asking for you to share the CDOP report.

7 Of course, that CDOP report doesn't make any
 8 mention of it because you didn't know anything about it?

9 **A.** No.

10 **Q.** And also flagging in the second paragraph the
 11 need for a more systematic approach to neonatal deaths.
 12 We know that that turned out in the report as saying you
 13 need to follow the SUDIc protocol?

14 **A.** (Nods)

15 **Q.** If we just go over the page to put the balance
 16 of the email in. And we can see there a little bit more
 17 information about what is effectively going to the SUDIc
 18 issue because it's about the definition of what is
 19 an unexpected death.

20 And asking this question: how deeply the CDOP
 21 considers these deaths in terms of investigation
 22 recommendations given that many are unlikely to have
 23 a direct safeguarding element?

24 **A.** Mm-hm.

25 **Q.** Flagging that there are 11 deaths which

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1 presumably at the time you would have recognised as
2 being a significant number coming from the Countess of
3 Chester?

4 **A.** Yes. I don't believe I ever saw this email.

5 **Q.** We are going to come to that. But in terms of
6 the face of it, that seems to be what Ms Eardley is
7 asking about.

8 **A.** Yes.

9 **Q.** If we go back up a page, we can see that
10 Ms Eardley follows up on the 17th to the same inbox
11 asking whether there is a chance to have a look at it
12 and it also appears that she's telephoned because she
13 says: I have also left a message.

14 Now, that telephone number, is that just a generic
15 inbox, mailbox?

16 **A.** It would be the number for Ann McKenzie.

17 **Q.** And the following day, a response from
18 Ms McKenzie talking about just one part of her email,
19 namely the annual report, saying it hasn't been signed
20 off yet, but not dealing with a number of other matters
21 raised by Ms Eardley?

22 **A.** No.

23 **Q.** Now, you have just said a moment ago that you
24 don't believe you saw this email. Should you have been
25 shown this email?

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1 there is a Sudden Unexpected Death within a hospital?
2 The meeting felt that the response should be on
3 a case-by-case basis and the safeguarding doctor should
4 be involved in the discussion with a designated doctor
5 and a Rapid Response should be arranged if deemed
6 appropriate. The meeting felt this process should be
7 reflected in our procedures with clarification of best
8 practice."

9 So again, you talked about the other problems with
10 the SUDIc process in the community but this appears to
11 be a discussion focused upon SUDIc in hospitals?

12 **A.** Mm-hm.

13 **Q.** Do you have a recollection of this discussion?

14 **A.** I am just reading around it to see if it ...

15 Yes, because I am sure we were talking about
16 awaiting the Kennedy report and updating the procedures.

17 **Q.** The Kennedy report, being the updated RCPCH --

18 **A.** Yes.

19 **Q.** -- guidance which came out in late 2016?

20 **A.** '16, yes.

21 **Q.** But to your mind was there in fact on the
22 existing guidance any doubt that at the very least the
23 designated doctor should be contacted?

24 **A.** No.

25 **Q.** There should be a proper discussion --

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1 **A.** Yes.

2 **Q.** And was that a satisfactory response that
3 Ms Eardley received to all of issues that she was
4 raising?

5 **A.** No. It -- it just dealt with the annual
6 report, didn't it, not the other issues.

7 **Q.** But we can see that one of the things that
8 Ms Eardley is raising is the RCPCH's concern about the
9 SUDIc process?

10 **A.** (Nods)

11 **Q.** Well, we will see that theme developing?

12 **A.** Yes.

13 **Q.** It was mentioned, as you will recall, in the
14 16 September meeting that you didn't attend.

15 Let's move forward -- thank you, we can take that
16 down -- to the meeting on 20 November, INQ0017817.

17 As that's coming up, you will recall at the
18 previous meeting they parked the SUDIc issue to this
19 meeting, which is the one that follows?

20 **A.** (Nods)

21 **Q.** We can see that you do attend this meeting
22 towards the top right-hand corner. On page 2, some
23 discussion about the SUDIc issue and it's headed
24 specifically item 4 "SUDIc within hospital".

25 "Should a Rapid Response Meeting be held each time

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1 **A.** Yes.

2 **Q.** -- about whether or not the Rapid Response
3 Meeting needed to be convened?

4 **A.** Yes.

5 **LADY JUSTICE THIRLWALL:** That sounds rather like
6 what you described in Nottingham.

7 **A.** Sorry?

8 **LADY JUSTICE THIRLWALL:** Is that rather like what
9 you have described that you did in Nottingham?

10 **A.** Yes.

11 **LADY JUSTICE THIRLWALL:** Yes.

12 **MR DE LA POER:** If we go back up the page just to
13 the first page. We can see that Dr Mittal is present at
14 this meeting.

15 **A.** Mm-hm.

16 **Q.** Do you recall what his point of view was about
17 the fact that effectively a discussion ought to take
18 place with him for Chester every time there was a Sudden
19 and Unexpected Death and that there should be
20 a discussion about the Rapid Review Meeting?

21 **A.** I don't recall what his views were in that
22 meeting. But based on the -- based on the minutes of
23 the discussion I would make, I would assume that he was
24 in agreement with that.

25 **Q.** Now, at the previous meeting, the fact that

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1 there had been an increase in the number of deaths on
2 the neonatal unit was flagged because there was
3 reference to the Royal College report. I mean, at this
4 meeting was there any discussion directly with Dr Mittal
5 about well, what did you do during that spike? Were you
6 involved? Did you talk about Rapid Review?

7 **A.** I still don't think even at this stage that we
8 knew that there was a -- that there was cause for
9 concern.

10 We were just waiting for the report and it did --
11 when I think back that probably was quite passive, we
12 were waiting for this report, I suppose we trusted in
13 the process that it had been, you know, obviously
14 experts in the field would be completing this review and
15 we were just waiting for that.

16 So no, there weren't any the conversations took
17 place after the -- after the report was received.

18 **Q.** Now, you have characterised that as being
19 perhaps a bit passive and you have also made the point
20 that there were no concerns flagged to you.

21 But isn't a cluster in itself something that you
22 should have been absolutely focused upon? So cluster
23 that's taken place in your area, some of the babies that
24 you are going to look at or have looked at form part of
25 that cluster? Just help us to understand why it is that

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1 towards the second half of the page, firstly, that there
2 is a concern that CDOP did not appear to be alert to the
3 cluster of neonatal deaths and for at least some there
4 should have been a Rapid Response Meeting within
5 five working days of notification, so's effectively
6 a criticism of the failure to provide the SUDiC process?

7 **A.** Yes.

8 **Q.** And that there is a recommendation directed
9 effectively to you and your panel that:

10 "CDOP should consider whether its processes could
11 have detected cluster of deaths and initiated external
12 review more swiftly"?

13 **A.** Yes.

14 **Q.** Now, a number of questions around that
15 recommendation. Firstly, upon the evidence, it would
16 appear that some of the Executives at least within the
17 Countess of Chester received this report before
18 Christmas of 2016, so in other words it wasn't published
19 for at least a couple of months after they had it?

20 **A.** (Nods)

21 **Q.** From your point of view as CDOP chair, how
22 important was it that you knew about this recommendation
23 made directly to you as soon as possible?

24 **A.** Hugely important.

25 **Q.** Because this was in fact the very thing that

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1 you think that that wasn't something that was being
2 discussed?

3 **A.** Because the action was for there to be
4 an independent review commissioned. So we were assured
5 by that action. So -- and that that review would
6 identify the cause of the cluster. So that's why we
7 were waiting.

8 **Q.** So let's come to that report now. We can take
9 that down. We know in early February 2017 what is
10 called the dissemination copy of the Royal College
11 report was published by the Countess. For your purpose
12 you don't need to worry about the difference between the
13 two versions that existed.

14 Was that a report that you saw at the time that it
15 was published or that was drawn to your attention?

16 **A.** I saw I think I saw it around February time.

17 **Q.** Early 2017, that is when it was published,
18 yes?

19 **A.** Yes, because I remember -- I don't know if Ann
20 had sent it to me but it was a really poorly scanned
21 copy so then I went online to try and find it myself on
22 the website and it was the same poorly scanned copy so
23 yes, it had been published, not long after it had been
24 published.

25 **Q.** INQ0001954, page 20. Now, we can see here

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1 your panel had been discussing in September and November
2 and this was separate and independent confirmation that
3 there was a problem --

4 **A.** Problem.

5 **Q.** -- with the approach that the Countess was
6 taking.

7 Did you ever follow up this particular
8 recommendation in terms of looking at your processes and
9 how it might detect a cluster and why it didn't?

10 **A.** Yes, that was discussed at the next CDOP panel
11 meeting.

12 **Q.** So we will come to that in March.

13 **A.** And I think I had a conversation with

14 Fiona Harvey as well, didn't I, around that time.

15 **Q.** I'm sorry, Fiona?

16 **A.** Is it Fiona Harvey? No, it's not. Fiona ...
17 Reynolds.

18 **Q.** And what was your discussion with
19 Fiona Reynolds?

20 **A.** Around that -- the recommendation.

21 **Q.** Bearing in mind that you will have been aware
22 in general terms that the review had taken place -- the
23 visit for the review had taken place in September
24 because we can see that in the minutes of the
25 16 September the first discussions taking place, did you

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1 wonder why it had taken the best part of six months for
2 this report to be produced into the public domain and
3 into your hands?

4 **A.** No, I didn't. Do you mean upon receipt of the
5 report?

6 **Q.** Yes, upon receipt of the report?

7 **A.** Sorry.

8 **Q.** Did you think: gosh, that's taken a very long
9 time, I probably ought to find out why it's taken that
10 long?

11 **A.** No. I didn't.

12 **Q.** So let's move forward to the CDOP meeting on
13 24 March. INQ0001953.

14 **A.** I do recall thinking -- remembering -- why
15 haven't they come and spoken to us?

16 **Q.** Who do you mean by "they"?

17 **A.** The Review Team because obviously they were
18 talking about the process and talking about the role of
19 CDOP but no discussions had with myself.

20 **Q.** Even at this stage were you unaware that
21 Ms Dodd had had a short conversation with them and
22 discussed CDOP?

23 **A.** I don't believe I was aware of that.

24 **Q.** I am not suggesting that should have been the
25 totality, I think your evidence was that you should have

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1 that's an assumption.

2 **Q.** We see the initials "GF" and at times
3 "Gill Frame"?

4 **A.** Yes.

5 **Q.** Now, who was she and why was she at the
6 meeting?

7 **A.** So Gill Frame was the independent chair of the
8 Local Safeguarding Children Board and she had had some
9 conversations, I believe, with the Medical Director of
10 the hospital and she was aware of this recommendation
11 around the CDOP processes, so she wanted to come along
12 to this -- have this discussion around what action we
13 needed to take.

14 There was a suggestion that because the -- the
15 review hadn't looked at the children's individual case
16 notes that the Child Death Overview Panel would do that,
17 but then Gill Frame had -- who was not related to me in
18 any way by the way, Gill Frame had I believe spoken to
19 the Medical Director and that was already being
20 completed.

21 So the discussion was around we would want to have
22 sight of that as a CDOP to provide independent scrutiny.

23 So it's a result of the report, its recommendations, any
24 action we needed to take that Gill suggested that she
25 came to that panel. She wouldn't ordinarily be there.

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1 been spoken to?

2 **A.** Yes.

3 **Q.** So this is the meeting on 24 March. We can
4 see that you are present, Dr Mittal is present, as are
5 a number of other people including, as he was, detective
6 chief superintendent Nigel Wenham?

7 **A.** Mm-hm.

8 **Q.** In fact I think is Detective Superintendent
9 there.

10 If we go over the page to page 3, we can see that
11 most of the page is devoted to the neonatal review and
12 was this the first time that you gained further detail
13 around what had taken place in the review and why it had
14 been commissioned, or had you had any prior
15 notification?

16 **A.** I had had the report but this was the first
17 time there was a discussion. My copy's a bit blurry,
18 I don't -- here.

19 **Q.** I think that that's as we hold it, so
20 I apologise --

21 **A.** Okay.

22 **Q.** -- but we will do our best with it. Do you
23 recall who made this presentation?

24 **A.** It's so unfortunate that it's not minuted
25 particularly well. I am assuming it was Dr Mittal. But

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1 **Q.** She made a request of you in the last
2 sentence, it would appear to:

3 "... write to Alison Kelly outlining the
4 recommendations the panel have made and confirm that the
5 panel would not have had oversight of the death and an
6 update to be added to the chair's report"?

7 **A.** Mm-hm.

8 **Q.** Can you shed any light on that and what, if
9 anything, happened as a result?

10 **A.** Okay, this was as a result of the CDOP not
11 being notified of all of the deaths so we didn't have
12 that information over that period of time.

13 If that action was there for me to write to

14 Alison Kelly, I will have written to Alison Kelly.

15 The -- I -- it would be the CDOP administrator that
16 would have copies of those letters because I -- you
17 know, I didn't even have a secure email account at
18 this -- you know, I wasn't a member of staff so I can't
19 look to see if that letter was written and sent but I am
20 assuming that it -- it would have been because

21 I wouldn't have left that action outstanding.

22 **Q.** We can see over the page that there is at
23 item 7 further discussion about SUDIc in the context of
24 a hospital and an unexpected death, so again it appears
25 that that was also something that was under discussion

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1 separately at the meeting?

2 **A.** Yes.

3 **Q.** Then finally for this meeting, if we go to
4 page 10 --

5 **A.** I mean, there is another action there on 4 for
6 to write a letter. I remember writing that one, I don't
7 know why I can't recall writing the other, but I am
8 certain that I would have done.

9 **LADY JUSTICE THIRLWALL:** Is that the one at the top
10 of the page, the action?

11 **A.** There was -- no, it was relating to something
12 else, it was around child protection concerns.

13 **MR DE LA POER:** Now, at the top, this is
14 Child I's(sic) case, as I understand it. We can see the
15 cause of death is unascertained and that there was an
16 inquest and further this case has been delayed coming to
17 panel as it was part of the neonatal review of COSH and
18 the case was closed unexpected death.

19 Just a few points coming out of that. We know that
20 the Inquest for Child A took place on 10 October of 2016
21 which means that following that there was an opportunity
22 at least to discuss Child A's case on 20 November when
23 CDOP met and on 20 January of 2017, when CDOP met. But
24 it's not in fact until this meeting that Child A's case
25 was discussed.

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1 **Q.** Let's look briefly at the Form C for Child A.
2 INQ0001944.

3 **LADY JUSTICE THIRLWALL:** Just while that's coming
4 up, Mr De La Poer, when you introduced this document you
5 said it was Child I.

6 **MR DE LA POER:** Did I?

7 **LADY JUSTICE THIRLWALL:** Just for the shorthand
8 writer.

9 **MR DE LA POER:** No, that is entirely my error.
10 This is Child A.

11 **LADY JUSTICE THIRLWALL:** Yes, you have made it
12 clear since. It's just for the record.

13 **MR DE LA POER:** Thank you very much, yes.

14 So this is the Form C. Do you know when this form
15 would have been completed?

16 **A.** So what would happen is Ms McKenzie would
17 pre-populate some of this, but it would be, the Form C
18 would be completed in the meeting. But the cause of
19 death, the case summary that would have already been
20 completed and the list of anonymised documents will
21 already have been -- she, she would collate everything
22 into a combined Form B, so the front sheet essentially.

23 **Q.** So we have got the cause of death
24 "unascertained" at the top and if we go to page 3, we
25 will see that panel discussion as before under "Issues

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1 Do you know the reason for that?

2 **A.** Cases didn't come to CDOP until the Form B was
3 fully populated, so that would probably be the reason.

4 **Q.** Isn't the Form B populated before the inquest
5 takes place at the time of death?

6 **A.** I -- I --

7 **Q.** So the inquest had taken place on
8 10 October 2016. The death was in fact in October 2015.

9 **A.** Yes.

10 **Q.** I am just wondering --

11 **A.** Why the delay.

12 **Q.** Why -- why did it take effectively until the
13 third meeting after that inquest had been completed that
14 CDOP was discussing the case, whether you have any
15 insight into that?

16 **A.** I -- I don't know the -- I don't know.

17 I -- I would assume it would be around information
18 not being gathered from all of the organisations, from
19 all of the agencies. Often we had to send things back,
20 the information wasn't sufficiently detailed or there
21 was gaps. So it would take a long time to get something
22 ready to -- and perhaps there might be because obviously
23 it's -- the modifiable factors might be held within
24 agency records that wouldn't necessarily form part of an
25 inquest so I suppose that's why.

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1 identified", a confirmation of that verdict,
2 unascertained, and following that:

3 "... and therefore the panel agreed that the case
4 could be closed."

5 Now just help us to understand the approach of the
6 panel. We have got: in the case of Child A, it's gone
7 all the way through the inquest process, the cause of
8 death is "unascertained". It was a Sudden Unexpected
9 Death. You know that the SUDIc process was not applied
10 as it should have been in Child A's case because you
11 know by this stage that the Countess wasn't doing that.
12 You have had no further light shed on why Child A died
13 by the Royal College review.

14 Was it the right thing to do to close Child A's
15 case at this point or should the panel have thought
16 about whether further information should be sought and
17 if so from whom?

18 **A.** I suppose again the panel would be reliant
19 upon a concern being raised with them. So if the
20 Coroner had raised concerns, had the designated doctor
21 raised concerns, I mean obviously the police were
22 present in that meeting too, weren't they? I -- I think
23 that in cases such as this a neonatal death would be
24 assumed to be the -- the cause.

25 I'm assuming that's what's ticked on the next page.

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1 Q. Well, if we go to page 5, we can see --
 2 A. Yes.
 3 Q. -- "perinatal neonatal event" and let's just
 4 have a look at the text of that:
 5 "Death ultimately related to perinatal events."
 6 And some examples are given and what is included in
 7 that definition is also given. Now, the Coroner had
 8 conducted a full inquest and had reached a narrative
 9 verdict that said death was -- cause of death was
 10 unascertained. I mean, in reality, was that a box that
 11 could be ticked in this case because there was no
 12 information to say that it did relate to perinatal
 13 events?
 14 A. So if that was the professional judgment of
 15 the panel --
 16 Q. But --
 17 A. -- but in terms of categorisation, I mean it's
 18 stated, isn't it, "unascertained" in 10.
 19 Q. Well, it's repeated throughout the
 20 documentation this is an unascertained death.
 21 And so I appreciate this is a panel decision, but
 22 it needs to be hung on something, doesn't it? There
 23 needs to be something within the information that the
 24 panel can say, "This was a perinatal event that caused
 25 this death."

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1 for the deaths?
 2 A. Mm-hm.
 3 Q. Was that something that you were ever told?
 4 A. Never, until the meeting that I attended at
 5 the hospital.
 6 Q. Which we will come to in a moment, 27 April.
 7 A. (Nods)
 8 Q. Should you have been told that?
 9 A. Yes.
 10 Q. Why do you say you should have been told that?
 11 A. The Child Death Overview Panel needed --
 12 should have been notified of all of the deaths and
 13 should have been notified of the concerns. Obviously
 14 the police sit on the Child Death Overview Panel.
 15 However, there were other people that should have
 16 been informed before me, so that, you know, if there was
 17 those concerns they should have been reported to the
 18 police at the time, the local authority should have been
 19 informed, so that their Local Authority Designated
 20 Officer would be involved because it's a person working
 21 in a position of trust, so there were other
 22 investigative processes if those were the concerns that
 23 should have been the priority.
 24 My -- I would have wanted to know because of my
 25 role in terms of chairing the Child Death Overview

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1 And having had your chance to look at it all now
 2 and focus upon it, can you point to any perinatal event
 3 that applied in Child A's case?
 4 A. Can we go back to the first, the front sheet,
 5 please?
 6 Q. Yes, page 1.
 7 A. The panel was very reliant on the designated
 8 doctors that were part of that panel to interpret
 9 medical information to us.
 10 But, the cause of death was unascertained, so that
 11 should have transferred through to the final box on
 12 the -- the form.
 13 Q. Now, we've got one more matter to discuss
 14 briefly but before we come to it, I would just like to
 15 pause now.
 16 As part of this meeting where Child A's death
 17 was -- case was closed and where the Countess was
 18 discussed, we saw on that page that Ian Harvey was to be
 19 invited to the next --
 20 A. Yes.
 21 Q. -- CDOP meeting, which was due to take place
 22 in June. If I can just provide you with a bit more
 23 information, some of which you may already know.
 24 We know that the Consultants raised in June of 2016
 25 their concern that a member of staff may be responsible

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1 Panel.
 2 Q. And whose responsibility was it, was there any
 3 particular person with any particular role who had
 4 a responsibility to tell you?
 5 A. To tell me?
 6 Q. To tell the panel, yes, about these concerns?
 7 A. I don't know how much the designated doctor
 8 was aware because obviously he was a panel member.
 9 Q. Well, if I just pause you there. We will hear
 10 from Dr Mittal on Wednesday.
 11 But do I infer correctly from your answer that what
 12 you are saying is that the designated doctor is the
 13 conduit that you would expect such information to be
 14 passed to the CDOP?
 15 A. Yes.
 16 Q. Well, we will hear from Dr Mittal about what
 17 he did and didn't know.
 18 A. However, that doesn't take away the need to
 19 escalate if you are feeling that your concerns aren't
 20 being heard or are being blocked.
 21 You know any, every -- Working Together to
 22 Safeguard Children is really clear in terms of
 23 safeguarding being everybody's business and those
 24 concerns could have been reported to the police and the
 25 local authority by anybody working within that hospital.

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1 Q. We are going to come now just to the final
2 meeting that I am going to ask you about. You tell us
3 in your witness statement that you had a telephone
4 conversation with Mr Harvey on 20 April?
5 A. Yes.
6 Q. And I will just remind you of what you say:
7 "Mr Harvey stated that he was keen to learn lessons
8 and wanted to be transparent in terms of the neonatal
9 deaths within the hospital, hence contacting me in my
10 role as CDOP chair. I believe we had a conversation
11 about the modified Rapid Response for unexpected deaths
12 in the hospital going forward. I recall Mr Harvey
13 talked about the RCPCH report and they were assured that
14 there was nothing to be concerned about but going
15 forward the hospital would escalate any concerns to the
16 CDOP in a timely way."
17 A. Yes, because they hadn't.
18 Q. Because they hadn't.
19 Now, in that meeting, did he tell you what concerns
20 hadn't been escalated in a timely way?
21 A. No. It was a very brief phone call.
22 Q. But did he give you to understand that there
23 were some concerns that he wanted to tell you about?
24 A. It -- no. It's as a result of the
25 recommendation in the report about the hospital not

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1 health, police, local authority. I may well be the
2 independent chair but I am a social worker.
3 So that would seem, if we are going to be talking
4 about any concerns in relation to deaths, we would have
5 the three key agencies there.
6 So that's why I asked if Nigel would come with me.
7 Q. As you know, we have Detective Superintendent
8 Wenham's notes of that meeting. Have you had a chance
9 to look over those?
10 A. Yes.
11 Q. And do they accord with your recollection of
12 what was said?
13 A. I don't remember any reference to angel of
14 death and I think, I think I would. It may be that that
15 happened at the end of the meeting and I wasn't ...
16 I don't know. But I don't, I don't recall that.
17 Q. But other than that detail, do those notes
18 represent your recollection?
19 A. It's far more detail than I recalled because
20 I suppose the meeting very much was reassuring that, you
21 know, there had been this thorough investigation and
22 review they had looked at the case notes as well now;
23 nothing of concern.
24 And then it shifted when there was this -- it was
25 stated that there was -- they have looked at rotas,

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1 escalating. The conversation that I had had with
2 Fiona Reynolds, which again was around the hospital not
3 escalating the concerns, and the discussion that had
4 taken place in the Child Death Overview Panel.
5 So it was on the back -- it was, that's what he was
6 referring to; that they hadn't raised any concerns with
7 the CDOP around the cluster of deaths in a timely way
8 and that they would do so going forward.
9 Q. Were you then asked to attend a meeting on
10 27 April?
11 A. Yes.
12 Q. And were you asked if you wished to bring
13 anybody else from the panel with you?
14 A. Yes, because it was just a meeting that I was
15 invited to initially.
16 Q. And did you decide to bring Detective
17 Superintendent Wenham?
18 A. Yes.
19 Q. And, briefly, why did you choose a police
20 officer?
21 A. Firstly, as a member of the Child Death
22 Overview Panel because the question was whether I wanted
23 to bring anyone else from the Child Death Overview Panel
24 and I suppose given that it was in respect of child
25 deaths, from my point of view the three key agencies are

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1 staff rotas and that there was one member of staff who
2 was on shift during each collapse and it was a note --
3 and then of course you're thinking: What, what are we
4 being told here? This, this is gravely concerning.
5 So all of Nigel's notes, which obviously I am
6 assuming were contemporaneous notes that he was taking,
7 around everything before that I don't remember that.
8 What I remember vividly is that conversation and then it
9 being clear that the reviews that had taken place so far
10 hadn't ruled out anything untoward.
11 Q. What you tell us in your witness statement is
12 that Dr Jayaram -- well, you tell us. What was
13 Dr Jayaram's position in that meeting about whether
14 further investigations were required?
15 A. Yes, he felt that they, they did.
16 Q. And what was agreed between you and Detective
17 Superintendent Wenham about what would happen next by
18 the end of the meeting?
19 A. It was agreed that -- so Nigel spoke about how
20 this was very much a matter for his officers, that they
21 needed to secure case files and then I think he was --
22 he had another meeting some time after that and that
23 obviously started the investigation.
24 But I was clear coming out of that meeting that
25 there was something very worrying and Nigel had the same

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1 view and the fact that this was the first time that we
 2 knew this.
 3 **Q.** Were you given any explanation as to why you
 4 had not been told until that point?
 5 **A.** Not that I recall.
 6 **MR DE LA POER:** Ms Frame, thank you for answering
 7 my questions. My Lady, those are all that I have for
 8 this witness.
 9 **LADY JUSTICE THIRLWALL:** There are no more from
 10 anyone else?
 11 **MR DE LA POER:** No.
 12 **Questions by LADY JUSTICE THIRLWALL**
 13 **LADY JUSTICE THIRLWALL:** No, and I have no
 14 questions -- no, there was one thing actually, sorry,
 15 and it's really an administrative point.
 16 You have said a number of times that you were
 17 an independent chair, so self-employed and you had no
 18 access to the systems that everybody else was using.
 19 **A.** No.
 20 **LADY JUSTICE THIRLWALL:** So how were you given
 21 information?
 22 **A.** So I think the -- it was like a secure portal.
 23 I'm sure it was called Cryptshare. So the papers for
 24 the meeting would be sent to me, I could then read them,
 25 but then they -- so I wouldn't be able to access them
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1 something.
 2 **LADY JUSTICE THIRLWALL:** And so in terms of --
 3 **A.** That was a challenge.
 4 **LADY JUSTICE THIRLWALL:** Thank you. So in terms of
 5 looking at something on the portal, you could look at it
 6 obviously while you were online, but there was no --
 7 were you permitted to download things from the portal
 8 and keep them?
 9 **A.** No, I never did.
 10 **LADY JUSTICE THIRLWALL:** No. All right.
 11 Thank you. Sorry, Mr De La Poer, is there anything
 12 you want to add to that?
 13 **MR DE LA POER:** Not at all. No, thank you,
 14 my Lady.
 15 **LADY JUSTICE THIRLWALL:** No. In that case we will
 16 rise now and start again at five past 2. Thank you very
 17 much indeed for coming. You are free to go now.
 18 (1.04 pm)
 19 (The luncheon adjournment)
 20 (2.05 pm)
 21 **LADY JUSTICE THIRLWALL:** Ms Brown.
 22 **MS BROWN:** If we could call Ms Sindall, please.
 23 **LADY JUSTICE THIRLWALL:** Would you like to come
 24 forward.
 25

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1 now because it would time out in terms of the secure
 2 link to it. So that's how I received papers.
 3 Often I would travel to Sandbach and meet with Ann
 4 and we would go through things face to face. But, yes,
 5 that was an ongoing challenge because I wasn't
 6 an employee, I didn't have a secure email address.
 7 **LADY JUSTICE THIRLWALL:** That's what I was about to
 8 ask you. Could you receive emails?
 9 **A.** As long as it didn't contain any identifying
 10 information, then everything else would go via the
 11 Cryptshare. So this is why I have sort of struggled to
 12 go back and see did I send that letter, because it would
 13 be sat on a system in Chester's local authority.
 14 **LADY JUSTICE THIRLWALL:** Yes, I understand that --
 15 **A.** Yes.
 16 **LADY JUSTICE THIRLWALL:** -- from the perspective of
 17 trying to put together a statement. But in terms of
 18 doing the role, was that a disadvantage, not having, you
 19 know --
 20 **A.** Yes.
 21 **LADY JUSTICE THIRLWALL:** -- the usual communication
 22 channels?
 23 **A.** Yes, I think so and not being able to look at
 24 data, I suppose. You know, not being able to -- it
 25 wasn't there at my fingertips, I would have to request
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1 MS PAULA SINDALL (affirmed)
 2 Questions by MS BROWN
 3 **LADY JUSTICE THIRLWALL:** Do sit down.
 4 **A.** Thank you.
 5 **MS BROWN:** Could you please give your full name?
 6 **A.** It's Paula Margaret Sindall.
 7 **Q.** I think at the time of the events we are
 8 looking at, your name was Paula Lewis?
 9 **A.** That's correct.
 10 **Q.** You have provided a statement to the Inquiry
 11 dated 29 May 2024, is that true to the best of your
 12 knowledge and belief?
 13 **A.** Yes, it is.
 14 **Q.** Turning to your qualifications, you qualified
 15 as a Registered General Nurse in 1985 and worked on as
 16 a nurse on medical and surgical wards and on intensive
 17 care; is that correct?
 18 **A.** That's correct.
 19 **Q.** Did you ever work on a neonatal unit?
 20 **A.** No.
 21 **Q.** You qualified as a health visitor in 1992?
 22 **A.** Yes.
 23 **Q.** And then worked in the community as a health
 24 visitor and that I believe involved working with
 25 families where there were some safeguarding concerns?
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1 A. Yes.

2 Q. In terms of your employment with the Countess
3 of Chester Hospital, in 2009 you started working at the
4 Countess as a full time Band 6 nursing post, I think
5 later promoted to Band 7.

6 That role was to support Karen Milne, who was the
7 named lead for safeguarding children and domestic abuse?

8 A. That's correct.

9 Q. If we could just very briefly look at the
10 safeguarding team at the Countess of Chester at that
11 time. Alison Kelly the Director of Nursing, she was the
12 Executive lead for safeguarding children?

13 A. Yes.

14 Q. What was the extent of the contact you had
15 with Alison Kelly in relation to safeguarding issues?

16 A. She was always the Chair at the Safeguarding
17 Strategy Board meetings, so I knew her then, but apart
18 from that my direct management was -- responsibility, my
19 manager was Karen Milne.

20 Q. Yes, so you would -- if you had an issue it
21 was Karen Milne you would be speaking to; you wouldn't
22 be discussing day-to-day safeguarding issues with
23 Alison Kelly?

24 A. No.

25 Q. Do you yourself ever refer an individual case

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1 Q. I think he was the doctor on the Child Death
2 Overview Panel and also had responsibility for the
3 Sudden Unexpected Death in Childhood process?

4 A. Yes, he did.

5 Q. Then Dr Isaac had responsibility -- she was
6 the named doctor for safeguarding children and had
7 responsibility for supporting medical staff,
8 particularly the paediatricians, in terms of their
9 safeguarding responsibilities?

10 A. Yes.

11 Q. In terms of the two designated roles,
12 Karen Milne and Dr Mittal, how did they --

13 A. Karen Milne had a -- was the named role, the
14 designated nurse sat with the CCG.

15 Q. Sorry, the named nurse. Her interaction with
16 Dr Mittal, how did that operate?

17 A. It was a professional relationship. We could
18 communicate with Dr Mittal and -- if we needed to.

19 Q. In terms of other individuals involved with
20 safeguarding, we have seen that there are nurses, for
21 example on the Accident and Emergency Department, who
22 would spend some days with the safeguarding team in
23 order to take expertise and safeguarding into the
24 Accident and Emergency Department?

25 A. Yes, she spent one day a fortnight with us so

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1 to Alison Kelly?

2 A. I'm sorry?

3 Q. Do you yourself ever referring an individual
4 case to Alison Kelly?

5 A. The only time I may have referred something
6 directly or informed Alison Kelly indirectly about
7 something was in Karen Milne's absence. If she was not
8 available and there was what I considered to be
9 an important issue occurring in the hospital, I would
10 email Alison Kelly to inform her.

11 Q. But there's -- just to be clear, there is no
12 issue related to what we are looking at in this Inquiry
13 where you contacted Alison Kelly about?

14 A. No, none.

15 Q. In terms then, so Alison Kelly as the
16 Executive lead, then Karen Milne you have spoken about,
17 who was the designated nurse?

18 A. She was the named nurse and named
19 professional.

20 Q. She was your immediate boss?

21 A. She was my immediate manager.

22 Q. In terms of the paediatricians there was
23 Dr Mittal who was the designated doctor for
24 safeguarding?

25 A. Correct.

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1 that she had those additional skills and knowledge.

2 Q. That was Vivien Beswick?

3 A. That's correct.

4 Q. Then in terms of other individuals with some
5 involvement, there would have been -- we don't need to
6 go through the names but people who had some involvement
7 in domestic violence, children in care, adult
8 safeguarding, those would be the other sort of people
9 other roles in safeguarding that would be attached to
10 your unit.

11 A. In safeguarding but the adult safeguarding was
12 separate to the children's safeguarding team.

13 Q. So in terms of the children's safeguarding
14 team, we have got the two paediatricians, Dr Mittal,
15 Dr Isaac, yourself and Karen Milne and Alison Kelly as
16 Executive lead, so a relatively small team?

17 A. Yes, I think so.

18 Q. Did you consider that that was a sufficient
19 sized team to manage the caseload that you had to
20 manage?

21 A. No, it would be my opinion really that it
22 wasn't. I think we were an unusual set-up within the
23 Countess in that Karen Milne had a dual role as both the
24 named midwife for safeguarding and the named
25 professional for safeguarding. In other Trusts they had

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1 two distinct roles with the named midwife and the named
2 professional but Karen carried out responsibilities of
3 both of those roles on four days a week and I thought
4 that that was -- that put a lot of pressure on her and
5 on the team really in terms of resource.

6 **Q.** So what did you consider was in fact required
7 in terms of staffing levels within the safeguarding
8 team?

9 **A.** Well, I left my role in the safeguarding team
10 in 2022 and the size of the team at the point that
11 I left was greatly increased from how it was in 2015 and
12 has continued to increase since.

13 **Q.** So just talking about when you left, "greatly
14 increased", what do you mean by that, doubled?

15 **A.** So three times the number of hours in the
16 safeguarding children team as it stands now compared to
17 how it was in 2015.

18 **Q.** Given the size of the team when you were
19 there, what was the extent of the discussions between
20 the four of you, did that mean there were a lot of
21 discussions, were you a close team?

22 **A.** Well, I shared an office with Karen, we
23 were -- Karen was responsible for my supervision and we
24 had day-to-day informal supervision, if you like, if --
25 if I had any queries, we worked very closely together.

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1 people throughout the Trust as well as nursing staff,
2 occasionally I would have a query from one of the
3 paediatricians. The community paediatricians would more
4 frequently make contact to discuss concerns.

5 But it was mainly the nursing staff and the other
6 professionals apart from the medical staff.

7 **Q.** Was that because doctors would tend to go to
8 Dr Isaac; is that your understanding?

9 **A.** I don't know but, but that would be my
10 assumption.

11 **Q.** In practice, would that be nurses coming to
12 your office or would you be going to the ward when they
13 raised a query? How would it work in practice?

14 **A.** Well, we had a formal referral process. But
15 we also -- so we would pick up daily referrals, we also
16 had a telephone, a designated telephone with an answer
17 phone facility, so 3 am messages were not unheard of.
18 We also carried a bleep as well. But we were actually
19 only on site in office hours.

20 **Q.** You say as well in your statement you had an
21 open-door policy and that you and Karen Milne strove to
22 maintain a very visible presence across the hospital.
23 In practice, how were you doing that, how were you
24 maintaining a visible presence?

25 **A.** It was -- well, I used to call and pick up the

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1 The paediatricians, the named and the designated
2 nurse -- doctors weren't -- weren't in the same office
3 as us, they were situated with the paediatricians.

4 But they were accessible, we could walk to their
5 office and discuss any issues but we tended to
6 communicate with them mainly by email.

7 **Q.** How often would you meet as a group or would
8 you meet as a group, the four of you?

9 **A.** Really the only time I think that we met as
10 a group was at the Safeguarding Strategy Board meeting.

11 **Q.** Did that cause a problem in terms of you being
12 kept up to speed with safeguarding issues, looking back
13 now?

14 **A.** I don't think so. I don't know what I don't
15 know. So I am fairly sure that -- you know, that
16 Dr Isaac and Dr Mittal would -- you know, they were
17 mainly responsible, I think, for supporting the
18 paediatricians and I wasn't party to how that took
19 place.

20 **Q.** And in terms of your -- now looking at your
21 day-to-day role, you refer in your statement to
22 responding to enquiries and concerns raised by staff,
23 would that be safeguarding concerns raised by either
24 doctors or nurses?

25 **A.** Mainly nurses. Other therapists, although

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1 referrals from A&E every morning, we tried to call into
2 the children's unit every morning as well.

3 **Q.** Just stopping there for a moment, obviously we
4 are very interested in the neonatal ward. How often
5 would you visit the neonatal ward?

6 **A.** We -- we visited -- I didn't -- we didn't
7 visit the neonatal unit unless somebody raised a concern
8 but we were geographically situated very near to both
9 the children's unit and the neonatal unit.

10 I can't remember but I think in 2015 we were
11 actually on the corridor between the two, between the
12 children's unit and the neonatal unit. We moved
13 upstairs but we were still in the women and children's
14 building.

15 **Q.** So whereas you would go to the paediatric ward
16 on a regular basis, on a daily basis --

17 **A.** Yes.

18 **Q.** -- the neonatal was as and when you were
19 requested to go there?

20 **A.** Yes.

21 **Q.** Approximately how often would that be, do you
22 think? Once a month, once a week?

23 **A.** Probably at least once a week. And we tended
24 to attend meetings regularly on the neonatal unit in
25 relation to babies that were being discharged home where

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1 there were some level of safeguarding concern.

2 **Q.** The sort of safeguarding concern that you were
3 coming across most frequently in terms of the neonatal
4 ward, what would that have been?

5 **A.** Sometimes it was about babies that we knew
6 there were safeguarding concerns antenatally and those
7 babies were now born and on the neonatal unit so we
8 would be helping the staff to manage the safeguarding
9 aspects and the safe discharge from the neonatal unit.
10 But sometimes it would be that there were babies that
11 weren't known to our team but a concern had arisen on
12 the neonatal unit, for example there may have been some
13 interactions between parents that had caused concern or
14 some aggressive behaviour or something like that and the
15 neonatal unit would seek support from us in -- in
16 dealing with that from a safeguarding perspective.

17 **Q.** So broadly the safeguarding concerns were ones
18 that were concerns about parenting of the child when
19 discharged to that home environment?

20 **A.** If the -- sometimes we had babies on there who
21 weren't going to be going home with parents and
22 occasionally we used the neonatal unit as a safe place
23 for this child to remain until the local authority could
24 obtain the necessarily legal orders for discharge but --
25 but otherwise it was mainly about concerns within the

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1 **Q.** Yes, we are aware of that.

2 **A.** That was on there, we would put regular
3 updates on there, contact numbers. We also sent out
4 communications electronically about new initiatives
5 within safeguarding that we felt the staff needed to be
6 aware of.

7 **Q.** In terms of those notice boards was there ever
8 any notices that you put up that dealt in particular
9 with concerns that individual may have about a member of
10 staff, healthcare staff, working with children?

11 **A.** Allegations?

12 **Q.** Yes.

13 **A.** Not that I -- not that I recall.

14 **Q.** Training, if we can turn to that. One of your
15 roles was delivering face-to-face safeguarding training
16 from staff. It appears from your statement that that
17 was in fact a major part of your role; is that fair?

18 **A.** Yes. There's a mandatory requirement for all
19 staff across the hospital to have a level of
20 safeguarding children training. So our Group 3 staff
21 had face-to-face training --

22 **Q.** Just --

23 **A.** -- in addition.

24 **Q.** So we understand that Group 3 staff, that
25 those are charged with regular contact with children and

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1 family and to make sure the baby was being safely
2 discharged into their care.

3 **Q.** You say in your statement that you would visit
4 the A&E and the children's unit in response to
5 safeguarding concerns which is obviously a reactive--
6 when you were called --

7 **A.** Yes.

8 **Q.** -- you went, but you are saying that you would
9 go as a matter of course every day, would you, in any
10 event or would you just go when there was a requirement?

11 **A.** To the neonatal unit?

12 **Q.** No, to the A&E and the children's ward?

13 **A.** In 2015 the referral process to our team from
14 A&E was a paper-based process, so we had to go into
15 the -- to pick up those referrals. It's not now, it's
16 electronic, but 2015 it wasn't.

17 **Q.** What about poster campaigns, other ways in
18 which you would raise the profile of safeguarding, were
19 any of those means employed?

20 **A.** Every clinical area was required to have
21 a Safeguarding Board and the neonatal unit had one, the
22 paediatric unit had one, A&E, and all the adult wards as
23 well on which was detailed what to do if you feel
24 a child's being abused. The flowchart -- I don't know
25 if you have seen that, and the policy --

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1 families, so neonatal staff would be Group 3?

2 **A.** Group 3, yes.

3 **Q.** In terms of the training, you say that
4 Karen Milne, she would do some of the training as well;
5 is that right?

6 **A.** Well, Karen Milne designed the training and
7 the content of the training but she wouldn't have had
8 the capacity. We used to deliver training separately to
9 the midwives and midwifery and Karen would deliver that
10 training and then the rest of the -- the Group 3 staff
11 across the Trust, I would deliver that. We called that
12 the generic safeguarding children training.

13 **Q.** You say it was Karen Milne who was responsible
14 for the content of the training, what input did you have
15 as to deciding the content of the training?

16 **A.** Well, when -- Karen updated the training
17 annually and -- and I always understood the rationale
18 between what was included in that training and could
19 make suggestions if I -- if I was -- if I wanted to, if
20 I felt there was an issue that I had become aware of
21 that needed to be included, but it was Karen that
22 determined the content.

23 **Q.** But I think it was Karen Milne, your boss, and
24 she gave the safeguarding training to the senior
25 Executives, to Ian Harvey and Tony Chambers. Why was

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1 she delivering that training, not you?

2 **A.** It would have just been that she had the
3 capacity to do so and that was the best use of the
4 resources at that particular time.

5 **Q.** But the training would have been in a sense
6 standardised training, the standard safeguarding
7 training, would it?

8 **A.** I -- I am not -- I have seen only from the
9 package what was in the training that went to the
10 Executives and I think that was -- I think the
11 Executives have a Level 1 training, it wasn't a Group 3
12 training.

13 **Q.** In terms of Dr Isaac and the training, we have
14 seen some PowerPoints that you, it appears, delivered
15 some of the training with Dr Isaac. She was -- was she
16 generally providing the training to doctors and you
17 generally to nurses, was there that divide or --

18 **A.** Usually, yes. Some of the paediatricians did
19 attend the generic training events that I put on as
20 well, but mainly I think it was Dr Isaac that delivered
21 to the paediatricians.

22 **Q.** From looking at the PowerPoints in broad
23 terms, it appears that the training given to doctors and
24 the training given to nurses, say for example doctors
25 may be referred to the GMC, for example, but broadly the

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1 **A.** For Group 3 staff, yes.

2 **Q.** In terms of training to people who were not
3 healthcare professionals, so for example Non-Executive
4 Directors or volunteers, were you involved in training
5 in terms of safeguarding any of those individuals or
6 were you just focused on healthcare professionals?

7 **A.** Just focused on healthcare professionals.

8 **Q.** Just so we can have an overview of the
9 training that was compulsory at this time, you address
10 this in your statement and you say Group 3 staff, so
11 that would be the staff working on the neonatal unit,
12 whether nurses or doctors, they had to have Level 3
13 annual face-to-face training?

14 **A.** They had to have Level 3 but in addition they
15 had to do the e-learning Group 2 because there is
16 a requirement within the intercollegiate document for
17 them to have so many hours of training so they completed
18 the Group 2 e-learning and in addition annually Group 3.

19 **Q.** The e-learning, that was once every three
20 years, that was a more --

21 **A.** That was once every three years.

22 **Q.** In terms of the frequency that you were
23 putting on this training, how often were you putting on
24 the training, how far often was there an opportunity to
25 go --

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1 training was the same for Group 3; was that your
2 understanding?

3 **A.** I wasn't always aware of the content of the
4 training that Dr Isaac was delivering, it wasn't --
5 I think we had delivered joint training a couple of
6 times only but in between, I -- I wasn't aware of what
7 training.

8 **Q.** When you did deliver joint training, was the
9 training that she was giving consistent with the
10 training that you were giving broadly to nurses?

11 **A.** It was definitely in my opinion more focused
12 towards paediatricians and their responsibilities
13 towards non-accidental injuries. The training that
14 I delivered to staff didn't just feature -- didn't
15 feature that as heavily and can I just say the -- the
16 training that I delivered had to be delivered to a broad
17 group of people who would be attending and so it would
18 be that there might be bits in the training that were
19 relevant to some staff, yet other staff would need more
20 in certain areas and so, you know, I would always have
21 to signpost staff to where they could get additional
22 training as per their clinical role.

23 **Q.** But the Group 3 staff, so those involved with
24 children on a day-to-day basis, they would be given
25 specific training for their -- for Group 3 staff?

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1 **A.** Monthly.

2 **Q.** Was that because of the turnover of staff?

3 **A.** The turnover of staff and the fact that
4 obviously staff work weekends, nights and what have you.
5 So they had to have an opportunity for it to fit in with
6 their -- their working patterns, really.

7 **Q.** In terms of compliance, so the fact that staff
8 had to do this training, you say that in terms -- in
9 2015/2016, the Group 3 staff, compliance targets were
10 80%. Now, 80% doing the training of course means 20%
11 were not. So one in five were not. Did you consider
12 80% was an appropriate target?

13 **A.** At the time, I -- I didn't question it and it
14 was subsequently raised by the CCG. It was a target set
15 by the CCG for us to achieve.

16 **Q.** You say you didn't question it at the time.
17 Looking back now, do you think 80% was adequate for --
18 this is training for staff who are working on a regular
19 basis with children?

20 **A.** I think it had to take into consideration
21 people who were on maternity leave, people who were on
22 long-term sick leave, turnover of staff, I thought at
23 the time 80% was -- was reasonable.

24 **Q.** In terms of compliance, that was managed by
25 staff managers, so on a -- for nurses that would be the

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1 ward manager, would it?

2 **A.** Yes. And I think the experience would be when
3 they had their annual appraisal that there's a part of
4 the appraisal would consider whether or not staff were
5 compliant with their mandatory training requirements
6 which would include safeguarding children.

7 **Q.** But that compliance, who had trained, who
8 hadn't trained and what consequences there were of not
9 training, that wasn't something that you got involved
10 in?

11 **A.** No. We sent the figures to the HR training
12 department who then shared the figures with the managers
13 in the clinical areas.

14 **Q.** So you recorded in effect who attended
15 training and then you sent on those figures for someone
16 else to deal with?

17 **A.** Yes.

18 **Q.** You talk as well about a bi-monthly review of
19 safeguarding issues and training that was done, you
20 refer to a paediatric peer review by Dr Isaac. That was
21 every two months, was it?

22 **A.** I --

23 **Q.** About?

24 **A.** I recollect that it was every month -- every
25 other month but I can't be 100% sure on that.

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1 required medical input, we would be involving the named
2 doctor for safeguarding anyway as a matter of course.

3 **Q.** The fact that you say you weren't able to
4 attend those meetings because of caseload, is that
5 an indication perhaps that the team was overstretched?

6 **A.** In my opinion, yes.

7 **Q.** Just looking at external training, you
8 represented the hospital at the Local Safeguarding
9 Children Board Training and Development sub group.

10 What was the purpose of that group?

11 **A.** The purpose of that group was to pick up sort
12 of lessons to look at multi-agency training that was
13 available, to consider lessons and whether the lessons
14 from events that had happened should be included in
15 training and what kind of training that -- that would
16 take.

17 **Q.** Did that -- you say multi-agency, did that
18 training look at issues such as the requisite level of
19 concern needed before going to the police, would that be
20 something that would be covered in that training?

21 **A.** I -- no, I wasn't aware of that. I never came
22 across that training.

23 **Q.** What about training about in what
24 circumstances the Local Authority Designated Officer,
25 the LADO, should be informed about a member of staff,

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1 **Q.** That training, that was training where they
2 would consider cases that had been dealt with the
3 hospital and the learning obtained from those cases; is
4 that correct?

5 **A.** That was my understanding. I attended I think
6 two of those peer review because we were invited but our
7 caseload was -- so our workload was so heavy at times
8 that I couldn't often attend.

9 **Q.** Because if those bi-monthly meetings were
10 looking at the learning from the cases and your work
11 pressures meant that you could only do so infrequently,
12 was that a concern, does it mean that you weren't in
13 fact involved in the learning from cases that came in?

14 **A.** A lot of the learning for the peer review
15 sessions that I attended was around how the medical
16 staff had managed the cases in terms of investigations,
17 looking at X-rays. It seemed to be very medically
18 orientated.

19 **Q.** But in terms of if you were the port of first
20 call some of the safeguarding would it not have been
21 important that you as the safeguarding team were on top
22 of the current issues that were coming through the
23 hospital?

24 **A.** I think if -- if we ever had a child that was
25 attending where there were safeguarding concerns that

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1 concerns about a member of staff; would that be covered
2 in that training?

3 **A.** No, I already -- that was in Working Together.
4 So we were already aware of what the requirements around
5 referral to LADO was and it was in our Safeguarding
6 Children policy.

7 **Q.** In terms of the Group 3 staff, and you have
8 spoken about the fact they needed to do the two and
9 a half to three hours face-to-face training and
10 e-learning, would they also attend -- I think they could
11 attend the LSCB training. Was that something that
12 regularly in fact occurred, that staff would incur this
13 additional training?

14 **A.** Yes, yes we had staff that maybe had dealt
15 with a case around, for example, domestic abuse and the
16 impact on children and the LSCB hosted additional
17 training on that. There was additional -- the LSCB had
18 a very good -- we had a link on our intranet to the LSCB
19 training that our staff could access, so there was very
20 good training on female genital mutilation, lots of
21 additional skills that our staff might have felt
22 relevant to them in their role.

23 **Q.** So that additional training was available but
24 it wasn't monitored who was doing it; is that correct?

25 **A.** That's correct.

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1 Q. In terms of your liaison role, you talk about
2 liaising with other agencies and you speak particularly
3 about -- that that involved liaising with the police.

4 What was your understanding about the level of
5 concern you needed before the police could be contacted
6 in a situation where you were concerned about potential
7 harm to a child?

8 A. Well, I was aware of what was in the
9 safeguarding policy at that time and in Working Together
10 around if there was a concern about a child,
11 a deliberate harm to a child that that would necessitate
12 a referral to the LADO and that would then involve
13 a strategy discussion about whether the police should be
14 involved at that point that you didn't need to wait for
15 the outcome of an investigation. The LADO wouldn't do
16 an investigation anyway, she would oversee a process but
17 you shouldn't wait for the outcome of an investigation
18 before you make that contact.

19 Q. So to paraphrase, tell me if I am wrong, your
20 understanding was where you had a concern you referred
21 that and you didn't need to wait for an outcome, you
22 didn't need evidence; it was a concern that triggered
23 it?

24 A. You didn't need evidence. That wouldn't be
25 something that I would do. I mean if -- if that had

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1 so there would definitely would have had to have been
2 some discussion with the Executive lead for
3 safeguarding.

4 Q. If we can just look at some areas of policy
5 then. You have referred a few times to Working Together
6 so if we could just turn to INQ0014575 at page 54. So
7 this is --

8 A. Sorry, my screen --

9 Q. It will come up.

10 **LADY JUSTICE THIRLWALL:** It just takes a few
11 seconds.

12 **MS BROWN:** It just takes a little moment.

13 What you are going to see coming up in a moment is
14 an extract from Working Together that sets out the
15 requirements the obligations placed on the NHS under
16 section 11 of the Children Act 2004.

17 A. Yes.

18 Q. The third bullet point down, the third black
19 dot says there clear policies, so the obligation is to
20 provide clear policies in line with those from the LSCB
21 for dealing with allegations against people who work
22 with children.

23 Then it goes on to say what an allegation is:

24 "An allegation may relate to a person who works
25 with children who has behaved in a way that has harmed

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1 come to me in my role as a Band 7, I would have
2 escalated it to Karen Milne and would have expected an
3 escalation then to the Executive lead for safeguarding
4 and a strategy discussion fairly quickly and referral to
5 possibly the police but definitely to the LADO would be
6 a part of that strategy discussion.

7 Q. So if someone had come to you and said "well,
8 I have got a concern but I have no evidence", you would
9 have put them right that that was not the safeguarding
10 approach?

11 A. Yes.

12 Q. In terms of contact with the LADO, you say
13 that you had contact with the LADO about safeguarding
14 concerns from other agencies but you never made
15 a referral to the LADO yourself. We know in the case
16 concerning Letby that it was eventually Alison Kelly who
17 referred Letby to the LADO, but that didn't occur until
18 27 March 2018.

19 Did you consider that referral of a member of staff
20 to the LADO was something that had to be dealt with at
21 an Executive level or was that something that you -- you
22 could have done? Or indeed anyone could have done?

23 A. I think that if -- I think it would have to be
24 done with the -- with knowledge of the Executive lead
25 for safeguarding, it's quite a serious thing to do and

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1 a child or may have harmed a child, possibly committed
2 a criminal offence or related to a child or behaved
3 towards a child or children in a way that indicates they
4 may pose a risk."

5 So that I think is what you were explaining; that
6 it's suspicions, it's may have harmed, may pose a risk?

7 A. Yes.

8 Q. That would was the test, where you have got
9 concerns about someone working with children?

10 A. Yes.

11 Q. If we can go then to the hospital safeguarding
12 policy to see how it was set out there. If we could
13 turn to INQ0014165. This is -- it went through a number
14 of drafts but this is the Safeguarding and Promoting the
15 Welfare of Children policy that is going to come up on
16 your screen in a moment.

17 If we can go there to page 3 first. We see there
18 this policy at the top, under the Executive
19 introduction:

20 "This policy reflects the standards set in the
21 Cheshire Local Safeguarding Children Board, the LSCB,
22 manual of procedures."

23 Going down:

24 "Every adult has a responsibility to protect
25 children and as employees of the Trust we are duty bound

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1 always to act in the best interests of a child about
2 whom we may have concerns."

3 We see then this is the September 2015 policy and
4 signed by Alison Kelly?

5 **A.** (Nods)

6 **Q.** Who makes clear is the Director of Nursing and
7 the Executive lead for safeguarding children.

8 If we can go on then to page 4. It says there
9 a phrase that we have heard in this Inquiry:
10 professionals needed -- this is under where it says
11 "Serious case review", professionals needed to think the
12 unthinkable?

13 **A.** Yes.

14 **Q.** Were you aware of the case of Beverley Allitt?

15 **A.** Yes.

16 **Q.** Were you aware of Recommendation 13 -- you may
17 not know the number but the principal recommendation --
18 one of the recommendations of the Clothier Inquiry into
19 Beverley Allitt that her actions should serve to
20 heighten awareness in all those caring for children of
21 the possibility of malevolent intervention as a cause of
22 unexplained clinical events?

23 **A.** Yes.

24 **Q.** You say yourself in your statement at
25 paragraph 35 that:

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1 **A.** I think there was a certain, although we, the
2 policy was -- the training was updated annually, there
3 was the core part of the training that talked about
4 professional responsibilities and talked about harm and
5 what would constitute harm and it wasn't explicit at
6 that -- within that about who would cause the harm.

7 **Q.** Looking back now, given that phrase "think the
8 unthinkable", given the evidence that people find that
9 a difficult concept, to imagine that a nurse or
10 a healthcare professional might be harming babies, and
11 given the learning from Beverley Allitt, looking back
12 now, should that have been made more explicit in the
13 training?

14 **A.** I'm not sure about referral to Beverley Allitt
15 and I guess that was in 1991, 1994 the Clothier report.

16 Maybe we should have included a scenario that
17 involved where a child had been harmed by a professional
18 but in terms of children that come to harm, significant
19 harm and are killed, they are much more likely to be
20 harmed by people within the family or more recently
21 a greater awareness of extra familial harm rather than
22 harmed by somebody tasked with -- with caring for them
23 within the --

24 **Q.** So the training focused on the more likely
25 scenarios and didn't in fact cover this unlikely

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1 "For such a vulnerable children to come to harm at
2 the hands of someone entrusted to care for them is
3 horrifying and has resulted in staff such as me having
4 to think the unthinkable."

5 That rather suggests that in 2015 and 2016, you
6 weren't focused or maybe were not sufficiently alert to
7 the possibility that a member of staff could harm
8 a child. Is that the case?

9 **A.** No and I think that that comment in my -- at
10 35 it should have had: staff such as me having to think
11 the unthinkable again. I don't believe that I wasn't
12 thinking the unthinkable in 2015.

13 **Q.** In 2015/2016 you recognised, did you, that
14 suspicions about a nurse harming babies, if that had
15 been communicated to you was a safeguarding issue and
16 that that should have triggered safeguarding processes?

17 **A.** I would agree with that.

18 **Q.** Because we have heard from a significant
19 number of witnesses to the Inquiry who said that they
20 received no training on what to do if they had concerns
21 about a staff member harming a child and certainly from
22 going through the PowerPoints, it doesn't appear that
23 there's any reference to the possibility of harm by
24 a healthcare professional or what steps to take if there
25 were such concerns?

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1 scenario?

2 **A.** That would be correct.

3 **Q.** If we can just go back to the policy and if we
4 can go to now page 30. So this there under the
5 italicised paragraph, the next paragraph down, it says:
6 "If at any point a member of the Countess of
7 Chester staff feels that their concerns about a child
8 are not being acted upon appropriately, they must
9 discuss this with the safeguarding children team who
10 will take responsibility for ensuring the case is
11 appropriately managed."

12 This, from what we can see, wasn't explicitly
13 covered in the training and we know in fact that staff
14 at certain points did have concerns that their concerns
15 weren't being acted upon appropriately and didn't come
16 to you as the safeguarding team. Why do you think that
17 was? Why did that -- that system fail it is in the
18 policy that if you have got concerns and you don't feel
19 it is being appropriately managed, you come to
20 safeguarding team and no one did come to you -- to the
21 safeguarding team about those concerns; that is correct,
22 is it?

23 **A.** That is correct, yes.

24 **Q.** Do you think looking back there is a reason
25 for that, why that mechanism wasn't working?

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1 A. I think I have learnt a lot from reading the
2 transcripts as they have gone on. But I think the
3 paediatricians were following the Speak Out Safely
4 guidance and -- and that.

5 Q. If you could just maybe confine it to what --
6 why you feel as a trainer at the time people weren't
7 coming to the safeguarding team with this concern?

8 A. I -- I don't know and I'm surprised.

9 Q. If we can go then down because this then
10 does -- to pre-empt you -- talk about the Speak Out
11 Safely policy and it stays there:

12 "From time to time staff may have concerns about
13 care or treatment given to any patient."

14 And it goes on:

15 "Managers have a particular responsibility to
16 protect patients and to handle concerns about their care
17 in a way that will encourage the voicing of genuine
18 misgivings while at the same time protecting staff
19 against unfounded allegations."

20 So it does -- this policy does envisage the
21 possibility of allegations against staff but this policy
22 itself doesn't set out what to do, a step by step guide
23 about what to do if you had concerns about staff?

24 A. No, it doesn't.

25 Q. And as far as you are aware, was there any
157

1 will see your statement, you say that your response, had
2 you been aware of these concerns, would have been to go
3 to the LADO; that's not what happened here?

4 A. Mm-hm.

5 Q. We are trying to understand why what thought
6 was instinctive as a safeguarder didn't happen in
7 practice. Can you shed any light on that?

8 A. I don't know that. I mean, all I would think
9 as well in that a two and a half to three hour training
10 it is very difficult to cover every single eventuality
11 and scenario and the -- you know, as part of the
12 training we always signposted staff and made sure they
13 were aware of the policies that supported safeguarding
14 across the Trust.

15 But why? So I don't know whether staff don't read
16 policies. That would be a possibility. And I am not --
17 you know, because it was in the Speak Out Safely, there
18 was information about the LADO in that as well and very
19 clear about the times when a referral to LADO must be
20 made. Yet I don't know.

21 Q. When you became aware -- and we will come to
22 that in a moment, but when you became aware of the
23 concerns about Letby, and I think we will see that but
24 that was shortly I think you say before the police were
25 involved, so late, but nevertheless a year before the
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1 training or guidance or flowchart that set that out?

2 A. There were -- I thought there was a link,
3 actually, to the allegations policy, the LSCB
4 allegations policy.

5 Q. Yes, yes. So we see the LSCB, but in terms of
6 the training that was given to Countess of Chester by
7 the safeguarding team?

8 A. No.

9 Q. If we could then just turn over to page 32, we
10 see under the heading "Human Resources Department" --

11 A. Yes.

12 Q. -- "The Trust will act with speed to any
13 allegations of professional abuse. The Countess of
14 Chester will identify a senior manager who will have
15 responsibility for referral and ongoing liaison with the
16 Local Area Designated Officer regarding any allegation
17 made against a Countess of Chester member of staff."

18 I think you have already said that referral to the
19 LADO wasn't something that was in the training, the
20 Group 3 training, safeguarding training?

21 A. No.

22 Q. In this case, we know that the referral to the
23 LADO happened at a very late stage, 2018?

24 A. (Nods)

25 Q. Do you have any explanation as to why? We
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1 recommended, the information was sent to the LADO, did
2 you not think at that point: we need to take this to the
3 LADO, I need to make sure that this is being done?

4 A. I can't remember the exact timeline but
5 I think --

6 Q. Well, the timeline is that we will come to it
7 but you were aware, it seems from your statement,
8 shortly before the police were involved, so 2017, spring
9 2017?

10 A. (Nods)

11 Q. And the referral to the LADO took place in
12 2018, I think March 2018.

13 A. Right, okay.

14 Q. So a year later in effect.

15 A. I think that I assumed then that once the
16 police were involved, that the appropriate processes in
17 terms of investigation would be taking place.

18 Q. If we can just go to some of the
19 PowerPoints -- one of the PowerPoints. So INQ0108339.
20 So what's going to come up here is a PowerPoint in
21 a moment, this is a 2013 one, this has been picked
22 because this is a Group 3 one. There is a number of
23 PowerPoints, I think you have seen?

24 A. Yes.

25 Q. All slightly, slightly different but the key
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1 slides remain the same. If we can go to page 2, we can
2 see there the requirements, just to reinforce what you
3 have said, that Group 3 staff need to complete the
4 Level 2 e-learning model every three years and attend
5 a face-to-face training session each year and the 80%
6 compliance is set out there.

7 If we can then go to page 5. We see the principles
8 that you have referred to from Working Together that
9 everyone shares a responsibility for safeguarding and
10 promoting the welfare of children irrespective of
11 individual roles and that obviously was a key part of
12 your training; that's correct?

13 **A.** (Nods)

14 **Q.** Then if we can look at 6, page 6, the last
15 bullet point on that:

16 "It is simpler to lift the telephone than live with
17 the regret of not doing so."

18 To what extent was that part of a discussion, that
19 bullet point, of the point we have been discussing, that
20 you don't need proof but once you have got a concern,
21 you should act? Is that the point that's being made in
22 that bullet point?

23 **A.** Yes. I would rather if someone had a concern
24 that they pick it up and discuss it with us before we
25 decided if it met a threshold to take additional

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1 **Q.** What do you consider would have been the
2 correct response if a nurse or a doctor had come to you
3 saying they had concerns about a nurse, because they
4 were always on duty when there were unexpected and
5 unexplained deaths? What as a safeguarder would you
6 have said to that?

7 **A.** It would have set a level of concern but it
8 could be at that point if they were always on duty when,
9 when there was an unexpected death, whether there was
10 an issue around clinical competency, possibly. That
11 would be very different to coming and saying: we think
12 that this nurse may be deliberately causing some harm.

13 **Q.** Yes. They are clearly different but if the
14 nurse -- if the professional came to you and said "we
15 have concerns because the deaths are unexpected and
16 unexplained and they are always on duty", so that is
17 specific, so they are not saying we have seen anything,
18 but they are concerned because the deaths are unexpected
19 and unexplained and the same nurse is always on duty,
20 what was the correct, would you say, safeguarding
21 response to that?

22 **A.** I think I would -- I mean, obviously I would
23 be escalating that to Karen. But I would want to
24 understand more in relation to whether there was
25 a clinical competency issue and issues like that as

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1 actions.

2 **Q.** So that can go down now. So to witnesses who
3 say that they couldn't take action without proof, you
4 would say, would you, that to some extent when we see
5 that bullet point that was something that was covered in
6 your training, albeit not explicitly in relation to
7 staff members but the idea of acting picking up the
8 phone as a principle was something that was covered?

9 **A.** Yes. Can I say as well if we are looking at
10 training, that we have made the point that staff --
11 Group 3 staff also had to do the Level 2 e-learning.

12 **Q.** Yes.

13 **A.** Now, the Level 2 e-learning, Level 2 staff,
14 one of the core competencies per intercollegiate
15 guidance is that they understand professional abuse.
16 I don't know whether the Level 2 e-learning addressed
17 professional abuse, I don't know what the content of
18 that training was. So we can't just assume that because
19 it wasn't in the face-to-face training that it wasn't in
20 the Level 2 e-learning.

21 **Q.** Would it not have been important for you to
22 understand what was in the e-training so that you --

23 **A.** I -- I did the e-learning training but I can't
24 remember in 2015 whether it covered professional abuse,
25 I'm sorry.

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1 well.

2 **Q.** So you would refer it to someone more
3 senior --

4 **A.** No --

5 **Q.** -- first of all?

6 **A.** -- I would --

7 **Q.** To Karen?

8 **A.** No, I would discuss it with Karen but then we
9 would have a discussion, and a pretty quick one about,
10 you know, what else had been considered, was this -- was
11 this nurse -- were there any concerns about her
12 competency, irrespective I think of, of what might have
13 been occurred, I think one of the first things we would
14 have thought about was: well, should that nurse be
15 working there from this day while we think about whether
16 the clinical competency is an issue?

17 **Q.** If we can go to paragraph 26 of your
18 statement, you deal with this to an extent and you say:

19 "In the event of suspicions or concerns being
20 raised with me about a member of staff being involved in
21 deliberately causing harm ..."

22 So this is sort of one ramp up from a scenario
23 I have put to you, but if the concern was deliberately
24 causing harm to a child as opposed to suspicion that
25 there is a correlation, you say you would have escalated

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1 that immediately and would have:

2 "... expected the Executive lead for safeguarding
3 would be notified, consideration of the need for an
4 onward referral to the Local Authority Designated
5 Officer and police would take place as a matter of
6 urgency."

7 You use the word there "consideration" of the need.

8 Are there any circumstances if there was a concern
9 about deliberately causing harm to a child where it
10 wouldn't go to the LADO?

11 **A.** No, not.

12 **Q.** You don't there, but I think you have made it
13 clear in your answer, refer to any immediate action in
14 terms of removing the individual from --

15 **A.** That would be -- I would expect there to be
16 a strategy discussion initiated with a matter of
17 urgency. We would need to -- the first thing to do
18 would be to establish immediate safety in relation to
19 any other children, so that would form -- that would be
20 the initial thing. How can we make the situation safe
21 now and what do we need to be doing in terms of
22 referrals to LADO and possibly the police if -- if there
23 is suspicion of criminality?

24 **Q.** So, Ms Sindall, your response is admirably
25 clear about what you felt were the stages to take but we

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1 **A.** When you talk about Dr Jayaram --

2 **Q.** Dr Jayaram was expressing his concerns --

3 **A.** His concern.

4 **Q.** So no suggestion of anybody witnessing, but
5 simply a concern --

6 **A.** Right. Okay.

7 **Q.** -- that these -- a child or children in that
8 case were considered at risk?

9 **A.** I think that that would form part of
10 a discussion with the LADO and the LADO should have been
11 informed really immediately and part of the -- because
12 they are available on the phone as well, the LADOs, and
13 I have spoken to them on the phone, so you would be able
14 to pick up the phone, speak to the LADO and say: we are
15 going to make a formal referral but this is the concern.
16 And I'm fairly sure, knowing the LADOs that I have had
17 contact, with that they would have been discussing the
18 need to inform the police.

19 **Q.** If we can just look at something slightly
20 different now, the Safeguarding Strategy Board. So if
21 we could go to INQ0102620, so this was the -- it's going
22 to come up in a moment, the Terms of Reference for this
23 board, Ms Sindall.

24 This was a board that you sat on as the
25 Safeguarding Strategy Board?

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1 know that when Dr Jayaram raised a concern, in fact
2 a specific concern that he was concerned about harm
3 being caused to one of the Triplets after their sibling
4 had died, that none of those steps were taken; that the
5 nurse wasn't removed from the situation, there wasn't
6 an immediate referral up.

7 Have you got any insight from your position as the
8 safeguarding team who were doing the training of the
9 staff of why -- why that occurred, why the nurses,
10 senior nurses, Karen Rees, Eirian Powell, Alison Kelly
11 it appears didn't view that as a safeguarding concern?

12 **A.** I don't know and I'm very surprised.

13 **Q.** In terms of the police, at what point would
14 you have been considering the police in that scenario,
15 so we have got a precise scenario in fact because we
16 have got a Consultant who's concerned about a nurse,
17 who's been present at a number of unexpected and
18 unexplained deaths and then is talking about a specific
19 concern related to a specific baby on the ward at that
20 time?

21 **A.** That -- immediate I would have thought. It
22 would need to go to the -- if you are talking about
23 deliberate harm to a child and that's been witnessed.

24 **Q.** Well, I don't think anyone is suggesting
25 witnesses --

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1 **A.** Yes.

2 **Q.** These are the Terms of Reference, so it just

3 sets out what that board was intended to do. It met
4 every two months, we will look at the attendees in
5 a moment but you attended as did Karen Milne, Dr Isaac,
6 Dr Mittal, Alison Kelly, Sian Williams, Julie Fogarty
7 and the Deputy Director of Human Resources,
8 Dee Appleton-Cairns. Just before we look at these terms
9 of reference, why was there the Director of Human
10 Resources, Dee Appleton-Cairns, what was the relevance
11 of her being on a safeguarding -- it may seem obvious to
12 you but why would you have someone from human resources
13 on a Safeguarding Board?

14 **A.** Because there has been recommendations before
15 around staff recruitment, Disclosure and Barring Service
16 and also because HR would be involved if there were any
17 sort of allegations against staff. So it's important
18 that HR policies have a link up in some way with
19 safeguarding.

20 **Q.** If we can just look at that, it's come up now.
21 So the sixth bullet point down. At the very top it says
22 the purpose, it reports to the Quality & Safety Patient
23 Experience Committee, responsible for ensuring
24 safeguarding is the strategic objective within the
25 Trust. Then it talks about the duties.

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1 The sixth bullet point is:

2 "To ensure that the Trust is reporting effectively
3 to external agencies when we have safeguarding
4 concerns."

5 So to that extent, in terms of the duties and what
6 it was trying to achieve, the Safeguarding Strategy
7 Board in this case, it failed, didn't it?

8 **A.** Yes.

9 **Q.** If we can just then turn to the INQ0043309, so
10 this is just an example of an agenda for the
11 Safeguarding Strategy Board on 15 April. We can see
12 there that at point 9, LADO cases -- sorry it's just
13 come up -- would be considered?

14 **A.** Yes.

15 **Q.** Lessons learned. I think compliance is
16 generally discussed.

17 We see at 10, the fourth bullet point down,
18 learning from significant incidents, local/national. So
19 learning from other incidents was something that would
20 be on the agenda and if we could then go over to page 3.
21 So what this pack of documents appears to be is there is
22 an agenda and then attached to the agenda in the normal
23 way are the minutes of the last meeting --

24 **A.** Yes.

25 **Q.** -- and then some other documents?

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1 **A.** I don't.

2 **Q.** But had you had a pack with documents you
3 would presumably have normally have read it?

4 **A.** I would try to before the meeting.

5 **Q.** Looking there, though key points, what's your
6 view about those points, do you agree with that, bearing
7 in mind this is talking about what were the key learning
8 points from this Trust in relation to a situation where
9 concern was raised about a member of staff harming
10 patients, in fact harming children?

11 **A.** Well, it has --

12 **Q.** Yes, do you agree with it, do you feel these
13 are useful points?

14 **A.** Yes.

15 **Q.** Just going through them, we see there
16 escalation at early action as per safeguarding policy;
17 early disbelief must be an explanation, communications
18 with patients and families, and they note: superb
19 support from the police at the beginning of the
20 year-long experience.

21 That is what I think we have established you would
22 expect to happen where there was a concern about a staff
23 member?

24 **A.** Yes.

25 **Q.** So the question is it would appear that this

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1 **A.** Yes.

2 **Q.** If we just look at the minutes there of the
3 meeting, we see -- actually if we can go on to page 4.

4 We see there compliance, for example, is one of the
5 things that would be discussed and it says there Group 1
6 and 3., so Group 3 is what we are interested in for the
7 neonatal unit, neonatal are above 80%.

8 Then in terms of the other documents that were
9 attached to this, do you remember when you received
10 agendas and minutes receiving other documents?

11 **A.** Yes.

12 **Q.** Attached?

13 **A.** There would be a big bundle of attachments.

14 **Q.** In this document, one of those attachments and
15 if we could turn, be calling up while I am setting this
16 out, page 102, one of the attachments here was a set of
17 PowerPoints that came from another Trust in which there
18 had been a concern about a member of staff harming
19 patients and in fact who was later convicted of sexual
20 abuse in that case that was the harm being caused to the
21 patients in there and this PowerPoint set out key
22 points.

23 Now, I think your evidence is that you don't

24 actually recall seeing this at the time, this

25 PowerPoint?

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1 learning was being shared and we saw from the agenda
2 that one of the items was learning lessons from other
3 areas, learning from significant incidents.

4 This was in April 2016, so before for example
5 Child O and Child P had died, had been murdered. Do you
6 think there was a failure to incorporate that learning
7 into the training?

8 **A.** That PowerPoint to my knowledge, I had never
9 seen it until it came through in my bundle, so I don't
10 recall there being any discussion of it at the Strategy
11 Board meeting at all.

12 **Q.** Setting aside that, so you don't recall it,
13 but do you think in fact that is the sort of thing that
14 should have been within the training, thinking now?

15 **A.** The whole PowerPoint or the --

16 **Q.** Not necessarily the whole PowerPoint but those
17 messages that don't appear in the PowerPoint at the
18 Countess of Chester?

19 **A.** Yes, some of those messages could have been
20 incorporated into the training.

21 **Q.** Is there any one you want to pick out in
22 particular or broadly, is that the message, I am not
23 saying that PowerPoint, but those --

24 **A.** I think escalation and early action as per
25 safeguarding policy, so it's clear that somebody

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1 understood the safeguarding policy at that hospital
2 Trust.

3 **Q.** Just returning to when you first recall being
4 made aware that there were concerns about harm being
5 done to babies, just take it in stages. When did you
6 first become aware that there were increased mortality
7 and concerns about that?

8 **A.** I had -- I was aware that there was a review
9 that had been ordered by the Royal College of Child
10 Health and Paediatricians in relation to increased
11 mortality.

12 **Q.** Was that the first time because of that review
13 that you learnt about increased mortality or --

14 **A.** Yes, and I don't know how I learnt about that
15 review. But -- but that was the first time I was aware
16 that there was increased mortality on the neonatal unit.

17 **Q.** And did you at that point think were you aware
18 that those were sudden and unexpected -- unexpected and
19 unexplained deaths or --

20 **A.** No.

21 **Q.** -- did you not have that level of knowledge?

22 Had you known that those were unexpected deaths,
23 what would your view have been about the SUDiC
24 procedure, would you have considered that should have
25 taken place?

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1 **A.** No.

2 **Q.** But the understanding you had insofar as you
3 had an understanding was that it wasn't put in place
4 where the death occurred in hospital?

5 **A.** I -- I --

6 **Q.** You just didn't know?

7 **A.** I just didn't know.

8 **Q.** In terms of when you recall first being made
9 aware that there were concerns that a nurse was possibly
10 harming babies, when did you become aware of that?

11 **A.** When Karen Milne returned to the office after
12 she had a one-to-one with Alison Kelly, which was
13 a routine -- her supervision was with Alison Kelly and
14 I noticed a real change in her demeanour when she came
15 into the office. She seemed really quite upset and
16 I said: how did your one-to-one go?

17 And she told me that Alison had discussed with her
18 not that she was seeking advice but had discussed with
19 her that they were going to call the -- either had
20 already or were about to call the police in relation to
21 concerns that somebody was -- that a member of staff was
22 involved in harm to the babies on the neonatal unit.

23 **Q.** It is that detail that helps us to date it
24 because that would suggest that this is March/April 2017
25 if it was just after or just prior --

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1 **A.** We didn't really in our side of the team,
2 Karen and myself, have an awful lot to do with SUDiC, we
3 very much saw it as a responsibility of Dr Mittal.

4 **Q.** Was that the case also for the Child Death
5 Overview Panel?

6 **A.** Yes.

7 **Q.** Did you understand SUDiC was the process would
8 take place if there had been an unexpected death in
9 hospital?

10 **A.** No, I didn't.

11 **Q.** You didn't think SUDiC was -- took place where
12 death had been in hospital or you didn't know, sorry?

13 **A.** I didn't -- I knew it took place. I mean, the
14 experience that I had had around SUDiC in relation to
15 attendances at the hospital were those deaths that
16 occurred outside of the hospital and came into the
17 hospital.

18 **Q.** If someone had come to you and said "there's
19 been an unexpected, unexplained death" what would you
20 have done? Would you have referred that to Dr Mittal is
21 that your evidence?

22 **A.** I would have thought that the paediatricians
23 would be involved anyway.

24 **Q.** So you -- is it right to say you didn't have
25 involvement with SUDiC?

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1 **A.** I don't know, I don't know when it was.

2 **Q.** But as far as you were concerned, it was
3 either just after or just before the police were
4 involved?

5 **A.** It was either at the time or a day or two
6 before.

7 **Q.** So just looking at that, by this stage, by
8 March/April 2017, we have had the RCPCH review and Letby
9 in fact was moved off the ward back in July 2016.
10 There's been the RCPCH review, there's also been
11 a grievance procedure. Were you aware of the grievance
12 procedure?

13 **A.** Not until I received the bundle.

14 **Q.** There's been significant numbers of meetings
15 between the paediatricians and the Executives and there
16 is clearly a huge issue and a huge safeguarding failure
17 that has occurred to get to the stage where the police
18 are being called at this event in 2017 and I am just
19 wondering if you can assist on the apparent disconnect
20 between you delivering safeguarding training once
21 a month, attending a Safeguarding Board and yet the
22 safeguarding team, certainly in terms of you and
23 Karen Milne, were unaware, completely unaware that there
24 were concerns about a nurse harming babies?

25 **A.** I do wonder whether the status of the

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1 safeguarding team within the hospital wasn't as -- as
 2 high as it should be, that would have made it a more
 3 natural thing, maybe for the paediatricians to think.
 4 So, for example, head of safeguarding or something like
 5 that, there were just the two of us getting on with the
 6 day-to-day work and I don't think that our status within
 7 the hospital or our importance within the hospital was
 8 as it should have been.

9 **Q.** You are clear, are you, that despite getting
 10 on the neonatal unit, you say you worked proximity, you
 11 didn't hear anything about nurses talking about a nurse
 12 being moved off the unit or --

13 **A.** Nothing whatsoever.

14 **Q.** Can we just go to the last document then,
 15 INQ0004715. This is the annual report, the Safeguarding
 16 Children's Annual Report for 2016/2017 what involvement,
 17 if any, did you have in drafting that?

18 **A.** This was a document that was put together by
 19 Karen Milne that she relied on other people providing
 20 information contained within it. So, for example, for
 21 CDOP she would go to Dr Mittal and say: do you need to
 22 put any -- you know, do you have any information around
 23 CDOP?

24 I would put in -- she would ask me for information
 25 about the LSCB quarterly audits that I attended and any

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1 safeguarding and was that really adequate in what was
 2 the annual report of safeguarding, given what had
 3 occurred?

4 **A.** My understanding of that paragraph from
 5 discussion with Karen Milne is that she was given.

6 **Q.** Sorry, discussion at the time?

7 **A.** No, not at the time. Subsequently. Or
 8 I can't remember exactly when, not relatively recently
 9 but some discussion when that was put in there, that
 10 Karen told me that she was given that paragraph verbatim
 11 by either Alison Kelly or the Mel Kynaston, the
 12 Associate Director of Nursing, to put this in verbatim.

13 **MS BROWN:** Well, we can ask Alison Kelly about
 14 that.

15 Thank you very much, Ms Sindall. I have no further
 16 questions and there aren't any questions from any
 17 Core Participants.

18 Questions by LADY JUSTICE THIRLWALL

19 **LADY JUSTICE THIRLWALL:** Thank you, I have just got
 20 one question, if I may, Ms Sindall. Could we bring up
 21 on the screen INQ0043309. It was a single page of
 22 a PowerPoint presentation.

23 **MS BROWN:** I think it is page 102.

24 **LADY JUSTICE THIRLWALL:** Thank you, Ms Brown
 25 I omitted to make a note of that.

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1 learning from them that could go in the report or any
 2 new initiatives around early intervention, I would.

3 So it was a document that was pulled together by
 4 Karen but it contained information from lots of
 5 different people.

6 **Q.** If you can just go to page 19, so just to set
 7 this in context as well. So this was dated July 2017,
 8 it's -- so by July 2017 the police are involved. It was
 9 clear that multiple individuals had not reported their
 10 concerns about Letby to the LADO, in fact, they still
 11 hadn't taken place, that -- certainly for a prolonged
 12 period it hadn't been referred to the police and in
 13 essence there had been a safeguarding failure. It
 14 hadn't been picked up as a safeguarding issue.

15 We look then at the little paragraph there under
 16 "Countess of Chester neonatal unit investigation", it
 17 says:

18 "There were a cluster of neonatal deaths identified
 19 between June 2015 and June 2016 at the Countess of
 20 Chester which are being investigated by the Cheshire
 21 Police. As a result of this Inquiry some changes have
 22 been made to the Pan-Cheshire CDOP process called ..."
 23 The SUDiC protocol and then it goes on.

24 But there is nothing in that report by way of
 25 serious reflection as to what's gone wrong with

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1 That's it. Now, that was something that was
 2 provided at the time but you didn't see it?

3 **A.** No.

4 **LADY JUSTICE THIRLWALL:** And have no memory of
 5 looking at it?

6 **A.** That wasn't discussed at the strategy board.

7 **LADY JUSTICE THIRLWALL:** No.

8 **A.** I don't recollect it being discussed.

9 **LADY JUSTICE THIRLWALL:** You don't remember it, no
 10 all right.

11 So just the short question from me is they have got
 12 the starting point and then the second bullet:

13 "Early disbelief -- must be an explanation."

14 **A.** (Nods)

15 **LADY JUSTICE THIRLWALL:** Which -- I mean, you tell
 16 me what you think. It seemed to me that what that's
 17 saying is at the beginning people just don't believe the
 18 allegation and that there must be some other
 19 explanation.

20 **A.** Yes.

21 **LADY JUSTICE THIRLWALL:** Is that something which in
 22 your experience can affect the way people approach
 23 concerns?

24 **A.** I think so, yes. I do. And it's very hard to
 25 think that somebody in a position of care and that's

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1 trusted to provide that care and to -- to provide safe
2 care would deliberately want to harm, yes, I think that
3 it's -- it's a natural thing for people to say "surely
4 not".

5 **LADY JUSTICE THIRLWALL:** I suppose that's why
6 training is important, isn't it, to remind people as you
7 put it, thinking the unthinkable.

8 **A.** And I think that's why it was in the policy,
9 we need to think the unthinkable.

10 **LADY JUSTICE THIRLWALL:** Yes. Thank you. Have you
11 got anything else, Ms Brown?

12 **MS BROWN:** There is nothing else.

13 I think I have covered it in my questions but
14 Ms Sindall, was there any other reflection you wanted to
15 add? I omitted to ask the question.

16 **A.** Just I wasn't aware that -- when I got that
17 PowerPoint through, I wasn't aware that it had been sort
18 of sent as part of a bundle, so my question was around
19 the PowerPoint: how, I guess when we are aware when,
20 there is a multi-agency working and a child dies there
21 is a serious case review, there is a clear process to,
22 you know, discuss whether or not it becomes, does that
23 child becomes the subject of a serious case review,
24 there's certain learning that takes place that is then
25 readily available via the NSPCC host, a repository of

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1 that this certainly was shared.

2 **A.** Yes.

3 **LADY JUSTICE THIRLWALL:** We know how far it got,
4 certainly as far as you were concerned.

5 **A.** Yes.

6 **LADY JUSTICE THIRLWALL:** Yes, but thank you for
7 that and we have got your other reflections already. So
8 those are my questions.

9 No one else has any questions, so you are free to
10 go and we will break and we will start again at 20 to 4.

11 (3.22 pm)

(A short break)

13 (3.40 pm)

14 **LADY JUSTICE THIRLWALL:** Yes.

15 **MR DE LA POER:** My Lady, our final witness for
16 today is Dr Isaac. I wonder if she might come forward.

DR HOWYADA ISAAC (affirmed)

17 **LADY JUSTICE THIRLWALL:** Do sit down, doctor.

18 **A.** Thank you.

19 **LADY JUSTICE THIRLWALL:** Yes, Mr De La Poer.

Questions by MR DE LA POER

22 **MR DE LA POER:** Please could you give us your full
23 name?

24 **A.** Dr Howyada Isaac.

25 **Q.** Can you confirm please that you gave a witness

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1 all the serious case reviews, so that people who are
2 wanting to learn and maybe to pass on that learning can
3 access that learning that way.

4 When it happens in the NHS, and it may be my
5 naivety around serious cases, but when there's only --
6 a tragedy like this where children come to harm, there
7 is only one agency involved, I don't know whether these
8 children become subject to a serious case review and if
9 they don't, then the investigative process and the
10 learning from that isn't available or is it available?
11 Is there some national initiative or some national
12 mechanism around patient safety where incidents like
13 this when they occur, that learning that occurs as
14 a result of it is then available for, across the NHS?

15 I -- it might be my naivety, maybe it is.

16 The learning from Thirlwall will be available
17 publicly for people to reflect on and include in their
18 training but, you know, this one from Cambridge, yes,
19 they took it upon themselves to send out a PowerPoint or
20 was there, I would wish to understand the mechanism by
21 which learning around serious incidents like this,
22 serious safeguarding incidents, whether there is
23 an established mechanism for sharing that across the
24 NHS.

25 **LADY JUSTICE THIRLWALL:** Yes, thank you. We know

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1 statement to this Inquiry dated 25 June of this year?

2 **A.** I confirm.

3 **Q.** Is the content of that true to the best of
4 your knowledge and belief?

5 **A.** Yes. There is a slight error with the date
6 I was appointed as a Consultant, in the second
7 paragraph, I think.

8 **Q.** I am sure we will be able to correct that but
9 other than that, is the content true to the best of your
10 knowledge and belief?

11 **A.** Yes, it is.

12 **Q.** Let's deal with your background.
13 Did you qualify as a doctor in 1986?

14 **A.** Yes.

15 **Q.** Have you worked in paediatrics since 1990?

16 **A.** Yes.

17 **Q.** Did you become a member of the Royal College
18 of Paediatrics and Child Health in 1998?

19 **A.** Yes.

20 **Q.** I think you first became a Consultant in 2005;
21 is that right?

22 **A.** Yes, that's correct.

23 **LADY JUSTICE THIRLWALL:** 2005.

24 **MR DE LA POER:** That's correcting the error in your
25 witness statement, I hope?

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1 A. Yes.
 2 Q. Did you join the Countess of Chester in 2012?
 3 A. That's correct.
 4 Q. Did you join both as a Consultant and as the
 5 named doctor for safeguarding?
 6 A. Yes.
 7 Q. Now, in terms of what that role meant, was it
 8 your responsibility to ensure that the organisation you
 9 were working for, the Countess of Chester, met its
 10 safeguarding responsibilities?
 11 A. That's right.
 12 Q. Did that include the Countess of Chester's
 13 responsibility to protect children from harm?
 14 A. That's correct.
 15 Q. Now, being the named doctor for safeguarding
 16 is, would you agree, an important role?
 17 A. Yes.
 18 Q. It is a role which is identified in statutory
 19 guidance, isn't it?
 20 A. That's right, yes.
 21 Q. Just tell us very briefly, please, between the
 22 difference between the role of named doctor for
 23 safeguarding and that of the designated doctor?
 24 A. So the named doctor for safeguarding, I work
 25 for the Trust and I ensure the standards of safeguarding

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1 overall responsibility for safeguarding at the Countess
 2 of Chester?
 3 A. So I would have responsibility for the
 4 clinical, for the strategic, but Alison Kelly would be
 5 the head of safeguarding as my line manager with regards
 6 to the safeguarding part of my role.
 7 Q. In practice if there was a disagreement
 8 between the two of you about how to respond in the
 9 safeguarding setting, who has the final say on what
 10 should be done?
 11 A. So Alison Kelly would be the Exec team, so she
 12 would be above me. But if I -- if we disagreed, there
 13 is a method of escalation so I could escalate.
 14 Q. And so does it follow then that if she said
 15 no, we are not going to do that and you disagreed with
 16 her, you could nevertheless take another route to ensure
 17 that your view was carried forward?
 18 A. I could escalate but it would be hard.
 19 Q. And who would you escalate it to?
 20 A. So I could talk to Dr Mittal the designated
 21 doctor or I can and -- and through him escalate to the
 22 LADO.
 23 Q. Now, in terms of your line management by
 24 Alison Kelly, did you have one-to-one meetings with her
 25 as part of your safeguarding role?

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1 within the Trust are met. The designated doctor works
 2 for the CCG and looks into safeguarding within the
 3 primary care and outside of the Trust.
 4 Q. We know --
 5 A. And also other agencies including -- works
 6 very closely with social care, which we do as well.
 7 Q. Now, we see from your witness statement, we
 8 don't need to go through it, but you undertook a very
 9 substantial amount of training for the role of named
 10 doctor; is that right?
 11 A. Yes, correct.
 12 Q. During the period 2015, 16 and 17,
 13 approximately how much time per week or per month were
 14 you spending on the role of named doctor?
 15 A. So I am given two programmed activities per
 16 week which is equivalent to one day per week.
 17 Q. Did you find that that was sufficient for your
 18 safeguarding role?
 19 A. Yes, it was.
 20 Q. In terms of the safeguarding structure at the
 21 Countess of Chester, Alison Kelly was, as we understand
 22 it, the Executive lead for safeguarding?
 23 A. That's right.
 24 Q. Just help us to understand, that isn't a role
 25 named in statutory guidance unlike yours. Who had

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1 A. No, I didn't.
 2 Q. We have heard that other roles did have
 3 one-to-one meetings with their line manager. Why didn't
 4 you have one-to-ones with Alison Kelly?
 5 A. I only met her in the Safeguarding Strategy
 6 Board meetings but we never had one-to-one --
 7 Q. But was that something you ever asked for?
 8 A. No, I haven't.
 9 Q. Why not?
 10 A. I tend to have safeguarding supervision
 11 through Dr Mittal, designated doctor for safeguarding
 12 and it's more around the medical aspects of the service
 13 and it's not something that she has offered me either.
 14 I don't think there was a close relationship
 15 between us in that sense.
 16 Q. Can I just ask a direct question then.
 17 I mean, there wasn't a close relationship between us.
 18 Is that a euphemism for the fact that the two of you did
 19 not get on professionally?
 20 A. No, no, we just didn't meet -- we only met in
 21 the Safeguarding Strategy Board meeting.
 22 Q. If Alison Kelly became aware of a safeguarding
 23 issue, did you have an expectation that she would tell
 24 you?
 25 A. It's not something that had happened whilst

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1 I was there.

2 **Q.** I understand that but you are the named
3 doctor?

4 **A.** Yes.

5 **Q.** You are the person who is charged with in the
6 statutory guidance to ensure that the Countess meets its
7 safeguarding responsibility. Doesn't that mean that you
8 should know about every safeguarding issue within the
9 hospital?

10 **A.** I expect to know, yes, especially things that
11 would be within my role.

12 **Q.** I am not suggesting anything that Alison Kelly
13 came across, but if it is a safeguarding issue or
14 potentially a safeguarding issue --

15 **A.** Yes.

16 **Q.** -- although she may be senior to you in
17 management terms, the responsibility sits with you,
18 doesn't it?

19 **A.** Yes.

20 **Q.** And therefore you should be told everything,
21 shouldn't you?

22 **A.** Yes, I couldn't possibly manage everything on
23 my own because that's why we have safeguarding nurses
24 and they deal with other issues as well. But yes,
25 definitely we should have been discussed serious things,

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1 the safeguarding circuit as an opportunity to remind
2 safeguarders that they needed to be looking inward
3 towards members of staff as well as outward?

4 **A.** No, this is -- wasn't included in any
5 safeguarding training. It was my knowledge through
6 these cases was through the media.

7 **Q.** We are going to look now at Working Together.
8 INQ0014575 and we are just going to look at four pages,
9 we will start at page 2 and just run through with you,
10 if we may, Dr Isaac, how we get to page 54, so 52 first.

11 So we can see this is under the chapter
12 "Organisational responsibilities" and this is really
13 just so that we can track through how we get to
14 an important part of this document. It begins by saying
15 at paragraph 3 that section 11 places a duty on, among
16 other things, NHS organisations; do you see that?

17 **A.** Yes.

18 **Q.** If we go over the page, we will see that
19 paragraph 4 says: these organisations should have in
20 place arrangements that reflect importance of
21 safeguarding and promoting welfare of children. Then it
22 gives a list of effectively what, among others, NHS
23 organisations should have.

24 Now, one of those, we can pause briefly on, is the
25 third bullet point from the bottom which is a designated

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1 yes.

2 **Q.** We are going to have a look at three policies
3 in a moment just briefly, but before we get to that, as
4 part of your safeguarding training and no doubt your
5 wider medical training, were you aware of previous
6 situations where a member of staff had harmed patients
7 deliberately?

8 **A.** Within the Trust?

9 **Q.** No, not within the Trust within the NHS. I am
10 here thinking about Harold Shipman, Beverley Allitt,
11 Colin Norris, Victorino Chua?

12 **A.** Yes.

13 **Q.** Were you aware of all four of those cases?

14 **A.** I was aware of Harold Shipman and
15 Beverley Allitt.

16 **Q.** Does it follow from that that you weren't
17 aware that a nurse at a hospital not too far from the
18 Countess of Chester was sentenced in May of 2015 for
19 murdering two patients with insulin and poisoning
20 others; did you know about that?

21 **A.** I have -- I have -- I have heard about it in
22 Stockport, yes.

23 **Q.** Yes.

24 **A.** I have heard about it but not in detail.

25 **Q.** So was that not a case that was circulated on
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1 professional lead for safeguarding. And here that's
2 referring to a role such as you had, the named
3 doctor role; is that right?

4 **A.** Yes, for health providers it is named doctors,
5 yes, named professionals.

6 **Q.** Yes, and we see that in the brackets.

7 There is one other matter that appears under that
8 heading at 4 of what organisations should have, it is
9 just over the page, we have looked at it many times but
10 I would like to look at it with you:

11 "NHS organisations should have clear policies in
12 line with those from the local Safeguarding Children's
13 Board for dealing with allegations against people who
14 work with children."

15 There is then a list of three bullet points of the
16 way in which an allegation against an individual might
17 be framed.

18 The language, as we have observed many times, is
19 "may" or "possibly" or "may pose a risk". Did that
20 accord with your understanding at the time in 2015/16/17
21 of the way in which safeguarding allegations should be
22 thought about?

23 **A.** Yes.

24 **Q.** Now, just reflecting back on it. Did the
25 Countess of Chester have a clear policies in line with

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1 the local safeguarding children's board in terms of how
2 such allegations should be dealt with?

3 **A.** Yes, it was written in the safeguarding policy
4 and welfare of children.

5 **Q.** So we are going to get that that in just
6 a moment; that is where the clear policy is to be found,
7 is it?

8 **A.** Yes.

9 **Q.** Before we get to that, one final element of
10 this just to bookmark, page 57. We can see the third
11 and final bullet point on this page, that:

12 "A named doctor should be identified as well as
13 a named nurse."

14 Then four lines up from the bottom -- five lines up
15 from the bottom:

16 "Named professionals have a key role in promoting
17 good professional practice within their organisation,
18 providing advice and expertise for fellow professionals
19 and ensuring safeguarding training is in place."

20 So did it form part of your role to give advice
21 from a safeguarding perspective to your colleagues
22 within the hospital?

23 **A.** Yes, it was.

24 **Q.** That's a role that you have by virtue of being
25 a named doctor?

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1 triggered if there is a possibility that abuse has
2 occurred."

3 So again summarising that: was it your
4 understanding that whether or not abuse had occurred is
5 a matter for the multi-agency response. What's
6 important is that if there is a concern it is brought
7 forward to the multi-agency level?

8 **A.** Yes.

9 **Q.** So the final policy to look at is the Countess
10 policy, INQ0014165. If we look at page 3, I am sure you
11 can tell us as that comes up that there seemed to be
12 a number of fairly similar version of this document from
13 around this time that we have invited you to consider
14 ahead of time.

15 Do you know why the policy appears to have been
16 amended and updated a number of times?

17 **A.** I don't know but usually it's every couple of
18 years, so I'm not sure why there are so many versions of
19 it.

20 **Q.** Can you confirm that there are a number of
21 versions with, for example, this September 2015 date as
22 we see in the centre of page 3?

23 **A.** Yes.

24 **Q.** So if we go to page 11, is this series of
25 bullet points the process that you were talking about

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1 **A.** That's correct.

2 **Q.** Thank you, we can take down Working Together.
3 The next policy we are going to look at is the
4 Cheshire West and Chester Council Interagency Policy,
5 INQ0007918.

6 Now, is this a document that you are familiar with?

7 **A.** No, is this part of the LSCB, is it on the --

8 **Q.** This is Cheshire West and Chester Council.

9 **A.** Right, okay.

10 **Q.** It is the Threshold for Initiating
11 Safeguarding Procedures?

12 **A.** Yes.

13 **Q.** It is an interagency document?

14 **A.** Yes.

15 **Q.** If we look at the large paragraph in the
16 centre:

17 "Determining whether or not abuse of a person has
18 taken place is not always a straightforward matter,
19 particularly when concerns relate to neglect.
20 A judgment will be required about whether an act or
21 omission has caused significant harm. The multi-agency
22 arrangements for responding to concerns exist to
23 establish whether or not abuse has occurred. It is very
24 important that these arrangements [and it talks about
25 the discussion and the meeting at a strategy level] are

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1 that is contained within this policy?

2 **A.** Talking about with regards to?

3 **Q.** Working Together says there needs to be a very
4 clear policy --

5 **A.** Yes.

6 **Q.** -- at the local level about what it do if
7 abuse is suspected, if an allegation is made?

8 **A.** Yes.

9 **Q.** Is this the process, is my question?

10 **A.** Yes, there's a flowchart as well about how to
11 escalate and what to do.

12 **Q.** Is that the flowchart that we have heard
13 spoken about as being put up on the walls?

14 **A.** Yes.

15 **Q.** When we look at what's contained within the
16 policy, this part of it appears to focus upon a starting
17 position of when a child is suspected to have been
18 abused is admitted to the hospital; do you see that?

19 **A.** Yes.

20 **Q.** So it seems to start from an assumption that
21 the suspected abuse is from outside?

22 **A.** Yes.

23 **Q.** I mean, do you think that the Countess' policy
24 dealt adequately with the thinking that perhaps it could
25 be a member of staff who was responsible for harm?

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1 A. There is a section -- another section as well
2 about the whistleblowing policy.

3 Q. Yes.

4 A. If you suspect there is a member of staff who
5 are concerned. But over here, I think we are looking at
6 the common scenarios, this is a very uncommon scenario,
7 this is very rare and when we are looking at this policy
8 it was looking into most of the cases that we do get are
9 children who come in with bruises or injuries and as
10 paediatricians or nurses or medical staff or clinical
11 staff we have to deal -- and we suspect abuse and it's
12 never been, never -- you never for certain in child
13 protection, there is no certainty and it's all on the
14 balance or probability and suspicion. And this is the
15 commonest scenario that we do get.

16 Q. I was just going to ask about that because the
17 phrase "balance of probability" you use in your witness
18 statement. Balance of probability ordinarily means more
19 likely than not, or greater than 50% chance, whereas
20 "suspicion generally" or "possibility" or "may" allows
21 for a lesser degree of certainty?

22 A. (Nods)

23 Q. Which did you think was the correct level of
24 test that needed to be applied before you had
25 a safeguarding concern that you had to respond to?

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1 potentially take it to the LADO, that doesn't require
2 balance of probabilities at that stage, does it?

3 A. No, you have concerns, yes.

4 Q. Now, we have heard already about the
5 Safeguarding Strategy Board which as we understand it is
6 a board that reported to QSPEC; is that right?

7 A. Reported to?

8 Q. To the QSPEC meeting, the Quality Safety
9 Patient Experience Committee?

10 A. (Nods) I didn't attend that committee.

11 Q. Well, let's have a look at the document behind
12 it, INQ0102620. Now, when you say "I didn't" -- as that
13 is coming up, you didn't attend QSPEC but did you attend
14 the Safeguarding Strategy Board?

15 A. Yes.

16 Q. So if, as we bring that up, we have looked at
17 this already, we don't need to go over what we have
18 already looked at, it starts at page 16 within this
19 document. There's just one part of it that I wanted to
20 ask you about, which is at page 19.

21 We can see there under "frequency of meetings",
22 there is a provision within this policy for an emergency
23 meeting, do you see that?

24 A. Yes.

25 Q. Now, presumably an emergency meeting might be

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1 A. We get safeguarding concerns and we assess the
2 probability and we will -- with regards to escalation,
3 we don't have to be certain to escalate but we have to
4 have a degree of suspicion.

5 Q. Yes, but do you need to have so much suspicion
6 that you are right at the start saying it's more likely
7 than not that this is the explanation or can you have
8 a lesser degree of suspicion?

9 A. We can have a lesser degree of suspicion. And
10 when in this particular case when you get somebody
11 coming from outside, you will see all cases and decide
12 yes or no on balance of probability less likely, there
13 are different balances, or more likely or probable.

14 So it, it's -- we would assess and then when we
15 produce our report we will say on the balance of
16 probability we think this is likely or unlikely, yes.

17 Q. When you get to the back end of the process as
18 to making a finding as to whether or not there has been
19 abuse or neglect, then you are applying that standard,
20 is that what you are saying?

21 A. Yes.

22 Q. But at the start of the process in order to --

23 A. Yes.

24 Q. -- raise it with safeguarding and for
25 safeguarding to say this requires an investigation,

198

1 called if there was a very serious safeguarding concern
2 which was emerging at the hospital?

3 A. Yes.

4 Q. So does it follow that although this is
5 a strategy board for safeguarding concerns of the most
6 serious type, as in a particular case this board could
7 also discuss that?

8 A. It can, but I would expect to have discussed
9 it on a one-to-one before bringing it to such a large
10 group.

11 Q. Now, we will come back in a moment to
12 a particular Safeguarding Strategy Meeting, I just want
13 it ask you briefly about training. Again the Inquiry
14 has heard a lot about training. There's one document
15 I want to take you to, INQ0108344.

16 Now, this has got your name attached to it. Do you
17 see that towards the top?

18 A. (Nods)

19 Q. To whom were you providing this training?

20 A. As far as I remember, I was doing it jointly
21 with Paula Lewis to hospital staff. I don't think it
22 was specifically for medical staff, I think it was
23 generic training.

24 Q. There is only one slide -- and we have already
25 looked at it once today -- I would like you to look at,

200

1 page 74. This appears to be, if you like, the sign-off
 2 slide, the closing message, the "if you take away one
 3 thing from this talk, it is this", is that fair?
 4 **A.** Yes.
 5 **Q.** That is how you are signing off to everybody?
 6 **A.** Yes.
 7 **Q.** That it's everybody's business, if you have
 8 suspicions pick up the phone?
 9 **A.** Yes.
 10 **Q.** Presumably when you are telling all the people
 11 you are training: pick up the phone, you are telling
 12 them: pick up the phone to me or my colleagues in the
 13 safeguarding department?
 14 **A.** Yes.
 15 **Q.** Is that right?
 16 **A.** Yes.
 17 **Q.** When you provided training, was that the sort
 18 of message that you were giving at the end of every
 19 presentation that you made?
 20 **A.** Yes, it's -- to raise awareness of
 21 safeguarding is everybody's business.
 22 **Q.** Thank you. We can take that down. We are
 23 just going to look at somebody else's slideshow here.
 24 INQ0043309 and I think you heard questions after your
 25 colleague earlier this afternoon, so you will know the
 201

1 individual in this case a member of staff, they need to
 2 be suspended?
 3 **A.** Yes.
 4 **Q.** Is that the sort of advice that you would have
 5 been prepared to give back in 2016/7 if someone had
 6 brought such a concern to you?
 7 **A.** Yes.
 8 **Q.** We can see early disbelief must be
 9 an explanation.
 10 Did you have any experience of allegations being
 11 made against a member of staff and the reaction of
 12 people around as to whether it may or may not be true?
 13 **A.** Yes, I think that is a very natural reaction;
 14 that people don't think of somebody caring for children
 15 would harm children and especially when you think what's
 16 the motive. So yes, of course people will resist and
 17 will think there must be some other explanation.
 18 **Q.** So that is the staff and colleagues.
 19 Is it important for the safeguarders to think
 20 a little more clearly about it though?
 21 **A.** Yes, and we have been taught to think the
 22 unthinkable because the same thing happens when you get
 23 a parent coming with a child and a person doesn't want
 24 to think that the parent could be harming the child
 25 because that's not natural, but we were taught you have
 203

1 document we are going to have a look at, it is at
 2 page 102.
 3 It formed part of a pack for a Safeguarding
 4 Strategy Meeting in February of 2016 and it would appear
 5 that your colleagues in Cambridgeshire had provided this
 6 slideshow which they were circulating about an
 7 experience that they had had.
 8 Do you have a recollection of having seen this
 9 slide which forms part of about a 10-slide presentation?
 10 **A.** No, I can't remember.
 11 **Q.** It's provided to the Safeguarding Strategy
 12 Meeting as part of the material for that meeting.
 13 I mean, was there an expectation that you would read all
 14 of the enclosures for a meeting?
 15 **A.** Yes.
 16 **Q.** So if it forms part of the enclosures, would
 17 you expect that you did read this at the time?
 18 **A.** Yes, I would try my best, yes.
 19 **Q.** In terms of good practice, we can see
 20 "escalation and early action in accordance with the
 21 safeguarding policy and immediate suspension";
 22 presumably you would regard that as a very important
 23 albeit neutral step in a safeguarding investigation?
 24 **A.** (Nods)
 25 **Q.** That the moment there is concern about an
 202

1 to think the unthinkable.
 2 **Q.** Thank you and we can obviously see in this
 3 case that there was police support from the very
 4 beginning. In the case of an allegation of a crime,
 5 would you expect the police to be involved at the very
 6 start?
 7 **A.** I would.
 8 **Q.** Thank you. We can take that down now.
 9 So we are going to turn now to events at the
 10 Countess. The first thing is just to understand your
 11 geographical situation. We have heard from Dr Holt that
 12 you and she shared an office; is that right?
 13 **A.** Yes, Dr Holt was a new Consultant so she came
 14 in later, maybe when I was reading through the document,
 15 it was towards the end of the process.
 16 **Q.** So it was March 2016, I think that she --
 17 **A.** Yes.
 18 **Q.** -- joined?
 19 **A.** Yes.
 20 **Q.** Dr Holt replaced Dr Newby. Did you share an
 21 office with Dr Newby before Dr Holt started or did you
 22 just have your own office?
 23 **A.** No, I didn't share an office with Dr Newby.
 24 **Q.** Did you share it with any of the consultant
 25 paediatricians before Dr Holt?
 204

1 A. Yes, I did.
 2 Q. Who did you share it with? Do you want to
 3 just check the cipher list to make sure if ...
 4 A. Yes, it is V something. ZA.
 5 Q. Dr ZA.
 6 A. Yes.
 7 Q. So that position, did that apply up until
 8 March of 2016 when Dr Holt arrived?
 9 A. Yes.
 10 Q. So in the period that you were sharing an
 11 office with Dr ZA, did you become aware of the increase
 12 in mortality on the neonatal unit?
 13 A. I can't remember the exact date when I came
 14 aware of the increased mortality, but it was late and
 15 I definitely wasn't aware of the concerns of my
 16 colleagues until I met with Steve Brearey and his
 17 appraisal and that was the time when I was really aware
 18 of what was going on but before that I -- I wasn't
 19 really -- I may possibly have known about the mortality
 20 because there was the Royal College review, so
 21 I probably knew at that point. But I can't pinpoint
 22 a specific date --
 23 Q. But my question was directed to the period
 24 before March 2016 just thinking about the time that you
 25 were sharing an office with Dr ZA and whether you ever
 205

1 point during that time -- I don't know how much they
 2 were aware either because, you know, it was an evolving
 3 picture.
 4 Q. The Inquiry heard a great deal of evidence
 5 from them. From your point of view. In the event that
 6 your Consultant colleagues were discussing a particular
 7 member of staff, and discussing between themselves
 8 whether or not the association that member of staff had
 9 may be sinister, is that the point that they should have
 10 been talking to you?
 11 A. Yes, but I have not heard them discuss about
 12 a member of staff on the corridor.
 13 Q. Were you aware of the downgrading of the
 14 neonatal unit in July of 2016?
 15 A. I don't know when I became aware of the
 16 downgrading of the neonatal unit.
 17 Q. Well --
 18 A. I can't remember.
 19 Q. Were you aware that the Trust in the first
 20 early days of July 2016; were operating what it
 21 described as a Silver Command?
 22 A. Yes, I -- I have not heard that term but
 23 I knew that they were.
 24 Q. Looking at the list of invitees, it doesn't
 25 appear that any member of safeguarding was invited to
 207

1 spoke to her about it or whether she ever mentioned in
 2 passing to you that there had been an increased number
 3 of deaths; do you have any recollection of that at all?
 4 A. No, I wasn't aware.
 5 Q. Once Dr Holt joined, but before June of 2016,
 6 do you have any recollection of hearing about it from
 7 Dr Holt?
 8 A. No, I don't.
 9 Q. Looking back on it, does it surprise you that
 10 that wasn't bearing in mind that you are sharing an
 11 office with people who are experiencing that every day
 12 in terms of the thoughts about it, the discussions that
 13 they have told us they were having that nobody mentioned
 14 it to you?
 15 A. I -- we all -- we were all in a corridor, we
 16 had offices in a corridor and there was lots of doctors
 17 in that corridor, we all shared offices there. I think
 18 there were five offices and I possibly heard a baby
 19 died, heard something like that, but not heard the full
 20 story, not -- wasn't aware about the full extent of
 21 their concerns and their suspicions.
 22 You know, they discuss cases all the time, they
 23 discuss, you know, issues, they will stand in the
 24 corridor and talk but I wasn't aware of -- of the degree
 25 of their concerns. It -- I don't think they at that
 206

1 any of those what were very large meetings, we have
 2 heard 36 people in one room. Should safeguarding have
 3 been invited to that -- to those meetings?
 4 A. Which meetings?
 5 Q. The Silver Command meetings. There was
 6 a period of three days as consideration was given to
 7 downgrading the neonatal unit and setting in train
 8 a series of investigations and reports?
 9 A. I wasn't aware of those meetings.
 10 Q. Should you have been aware?
 11 A. If there are safeguarding concerns they should
 12 have let us aware, yes.
 13 Q. We know, for example, at the end of June just
 14 before that process started, that Dr Jayaram had
 15 conducted research about whether air embolism, the
 16 deliberate administration of that could be responsible
 17 for some of the deaths, so in other words he was
 18 investigating a possible murder method.
 19 Should you have been made aware that that was
 20 a piece of research that he was conducting?
 21 A. The first time I have heard of that was during
 22 the trial. I don't know when he was conducting that
 23 research, what period do you refer to?
 24 Q. You can take it from me that it was 30 June of
 25 2016.
 208

1 A. Right, okay.
 2 Q. Should you have been told about that?
 3 A. Yes.
 4 Q. Now, you were interviewed by the Royal College
 5 on 1 September?
 6 A. (Nods)
 7 Q. In the morning, Dr Jayaram and Dr Brearey,
 8 with support of the other five paediatric Consultants,
 9 had told the reviewers about their concerns that Letby
 10 may be deliberately harming babies.
 11 In your meeting with the Royal College that
 12 afternoon, were you told about those concerns?
 13 A. No.
 14 Q. Should you have been told?
 15 A. Yes.
 16 Q. In fact, if we just have a look at one perhaps
 17 striking example, INQ0014604, page 25. These are notes
 18 taken by the Royal College as part of their review.
 19 Do you see where it says the word "TOM"? In fact
 20 we have established that should say "team", that's just
 21 a mistranscription.
 22 This is the lunch time meeting of the reviewers.
 23 They spent part of the lunch discussing ways in which
 24 deaths may have been caused deliberately. You can see
 25 there "INS", "INS". We are not going to go into the
 209

1 Q. What did he tell you in that appraisal about
 2 the concerns that he had?
 3 A. So -- I went back for the purpose of this to
 4 read -- I remember that he told me about the increase in
 5 mortality rate going up to 13 babies from being 1 to 3
 6 and that this nurse was on duty every time a baby died
 7 and they've had concerns. And he's done some reflection
 8 notes there as well, which I have read through, and --
 9 and how he has escalated it to the managers but they
 10 haven't responded to him and at the time he was -- and
 11 he was concerned as well because of -- there was
 12 a grievance coming up and that he would be asked to sit
 13 in a mediation for several hours for this mediation
 14 process and grievance.
 15 Q. Now, in terms of what he told you about the
 16 increase in mortality, the fact that there was an
 17 association with a member of staff, and that he was
 18 concerned about that I mean he was telling you, wasn't
 19 he, that he was worried that that member of staff may
 20 have murdered babies --
 21 A. Yes.
 22 Q. -- is that fair?
 23 And that is a clear safeguarding concern, is it
 24 not?
 25 A. So at the time that wasn't regarded as
 211

1 detail of that. It should in fact say "insulin
 2 injection" or "air embolism". So they were discussing
 3 that at lunchtime.
 4 Can you that the very next thing that they record
 5 doing under that line is that they came to speak to you?
 6 A. They came to speak to me?
 7 Q. If we look, we can see that after they'd had
 8 that lunchtime discussion they met with you and with
 9 other safeguarding colleagues?
 10 A. Yes, yes, a joint meeting.
 11 Q. Yes, in the joint meeting.
 12 A. Yes.
 13 Q. Should they have told you about their
 14 discussion that they'd had at lunchtime bearing in mind
 15 your safeguarding role?
 16 A. Yes, yes, but that was not mentioned at all in
 17 our meeting. It was all general safeguarding policies
 18 and procedures in the Trust.
 19 Q. Thank you. We can take that down.
 20 So we are just going to spend a moment or two
 21 looking at your appraisal with Dr Brearey. You have
 22 told us that that took place on 22 November 2016 and you
 23 weren't meeting him as a safeguarder, but as
 24 a professional colleague conducting his appraisal?
 25 A. (Nods)

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1 safeguarding and I suspect that's why my colleagues
 2 haven't approached me as a safeguarding lead.
 3 The typical safeguarding scenario, like you pointed
 4 out, is a child coming through the door with bruises or
 5 injuries and you deal with that as a clear safeguarding
 6 case. But a member of staff causing harm to babies and
 7 murdering babies was thought to be like more of a crime
 8 that would require police investigation.
 9 Q. You --
 10 A. My colleagues are all very experienced in
 11 safeguarding and none of them had come to the
 12 safeguarding team and I -- I suspect, obviously I am not
 13 talking on their behalf, but I suspect it's because it
 14 wasn't as clear-cut as what we think now.
 15 Q. But you have --
 16 A. Another -- another thing I would like to point
 17 as well is at the time when I knew about it, this had
 18 already been escalated to the highest level. The senior
 19 management, the top, you know, in the hospital were
 20 aware of it and Lucy Letby had already been removed from
 21 the neonatal unit.
 22 So when we talk about safeguarding, we talk about
 23 children who are still alive and we are safeguarding
 24 them. But in this case, she had been already removed,
 25 the children were safe in the unit and we were dealing
 212

1 with child death and that's a different process to the
2 safeguarding.

3 **Q.** But by the end of November of 2016, plans were
4 afoot to return Letby to the ward. Doesn't that just
5 demonstrate why you should have intervened at that
6 stage?

7 **A.** Yes. If she were to be returned to the ward,
8 I definitely would have escalated it.

9 **Q.** But you didn't know unless you went and found
10 out what was going on and what the plan was?

11 **A.** But I was -- you know, I -- I had talks with
12 Dr Brearey at the time and -- and I was waiting to see
13 what would come out of the reports because you say you
14 don't have to be sure to raise the alarm bells, which is
15 correct, if you have suspicions, that's correct. But
16 when you are making a referral you want to give a good
17 quality referral.

18 And a lot of people were saying at the time and
19 would say, "This is just a coincidence, you can't blame
20 a member of staff because of rise of mortality. You
21 need to look into medical causes first. You need to
22 look into competencies. There could be other
23 possibilities."

24 But now, with the benefit of hindsight, we know
25 that she was guilty but at the time we didn't.

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1 **Q.** But bearing in mind what you have told us
2 about the fact that any serious safeguarding concern,
3 even if it's communicated to Alison Kelly, should be
4 given to you, were you not concerned that there had been
5 a failure here to notify you about this?

6 **A.** Yes. As a safeguarding lead, like I say
7 Dr Brearey, when he spoke to me, he wasn't referring to
8 me for safeguarding -- to -- for a safeguarding process
9 to be followed.

10 He was telling me this as part of his appraisal.

11 **Q.** If somebody tells you a safeguarding concern
12 in any context, you have a responsibility to act upon
13 it, don't you?

14 **A.** Yes, definitely. Yes.

15 **Q.** And looking back on it, do you think that in
16 fact at that moment, in November, you should have
17 immediately contacted Alison Kelly and said, "I'm the
18 named doctor. I need to know what's going on here"?

19 **A.** Yes, and -- and that's why I sort of wrote
20 a letter to Alison Kelly and to express concerns about
21 safeguarding the children.

22 However, I didn't send that letter. I was waiting
23 for more evidence from the reviews. I knew that the
24 babies were safe and that Lucy Letby was working in
25 a clinical -- in a non-clinical area.

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1 **Q.** But --

2 **A.** And -- and it's that sort of information I was
3 waiting for so that to escalate I would have that to
4 back me up.

5 **Q.** Well, did you ask Dr Brearey what his
6 Consultant colleagues thought in paediatrics on the
7 ward?

8 **A.** What they thought about ...?

9 **Q.** Yes, whether they agreed with him, whether
10 they were worried?

11 **A.** Dr Brearey told me that they, he -- they were
12 worried, that Dr Jayaram and himself were regarded as
13 troublemakers because of escalating this or raising
14 concerns.

15 He was the head of the department, so he was
16 talking on behalf of everybody else.

17 So he -- I don't know if the rest were worried or
18 not, but I know that, you know, I -- that he was, he was
19 sincere in what he was saying and I'm not saying that in
20 any way he was, he was wrong.

21 No, on the contrary, he stood up for the children.

22 What he did was right. And they had already
23 escalated it and they had already gone up to the chief
24 Exec and the Medical Director and they had -- weren't
25 listening to them.

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1 **Q.** Well, by January, it had been resolved at
2 board level to seek to return her to the ward. You
3 hadn't asked any questions, so you couldn't have known
4 that.

5 Didn't you need to find out about what the plan
6 was?

7 **A.** Yes, but I -- I knew that this is
8 a possibility and I would have escalated it if that were
9 to happen. In retrospect now, with the benefit of
10 hindsight, I, you know, I do wish I had sent that letter
11 sooner and I wish I had escalated it as soon as
12 Dr Brearey told me about this issue.

13 **Q.** Well, in fact you typed the letter on
14 7 February of 2017, so that was, well, over two months
15 later. I mean, do you think that that was an acceptable
16 period of time to leave it before you started writing
17 that letter?

18 **A.** No. In hindsight, I should have escalated it
19 earlier.

20 **Q.** Well, let's have a look at what was in your
21 mind on 7 February, INQ0102620, and we will need to go
22 to page 22.

23 So it begins with you making clear the capacity
24 that you are writing in and that was entirely
25 appropriate for you to do so, wasn't it? You were

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1 perfectly entitled to write to an Executive Director in
 2 those terms because this is your responsibility, isn't
 3 it?
 4 **A.** Yes.
 5 **Q.** And you are enquiring about the outcome of the
 6 investigations. So at this stage all you are trying to
 7 do is find out what's happening?
 8 **A.** Mmm mm.
 9 **Q.** And you pose two questions, which include
 10 whether the reason has been identified at the second one
 11 and if there has been an increase in risk to babies on
 12 the neonatal unit and you conclude by saying:
 13 "If these questions cannot be answered, then
 14 further investigations may be warranted to ensure that
 15 we are safeguarding children in our care and to ensure
 16 we can protect our babies from future risk."
 17 **A.** Yes.
 18 **Q.** Now, all you are doing is asking questions at
 19 this stage, aren't you?
 20 **A.** Yes.
 21 **Q.** Why didn't you send this letter?
 22 **A.** I was debating whether to send it or not and
 23 then I knew the investigation has happened, there was an
 24 investigation, we are going to get a review, and if we
 25 get a review and these deaths are confirmed as

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1 return her to the ward and a date for that was set by
 2 the Executives? Did you know that?
 3 **A.** No, I didn't. I knew there was talks about
 4 the possibility of her returning after the grievance
 5 process, but I didn't know there was a date set.
 6 **Q.** Again, looking at the situation as you now
 7 understand it to be, doesn't that rather tend to suggest
 8 that you not intervening and trusting that Dr Brearey
 9 would report to you what was going on wasn't really an
 10 adequate response by you given what was at stake here
 11 which was the safety of children? Do you agree with
 12 that?
 13 **A.** I agree.
 14 **Q.** Now, the final thing I want to ask you about
 15 is the Local Children's Safeguarding Board and related
 16 to that the safeguarding report that was prepared by
 17 your colleague Karen Milne. So we will deal firstly
 18 with the Local Children's Safeguarding Board.
 19 They should have been notified of what was going on
 20 at the Countess, shouldn't they?
 21 **A.** But that would have been through Alison Kelly.
 22 **Q.** But was it not your responsibility, as named
 23 doctor, to make sure that they knew?
 24 **A.** Yes.
 25 **Q.** And at any point in this time -- here we are

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1 unexplained, unexpected -- they are not due to medical
 2 causes -- then we -- there is more evidence to escalate
 3 it higher and there will be a stronger basis for doing
 4 this.
 5 And the review had already happened. We were just
 6 waiting for the report, so it's, you know -- and the
 7 babies were safe, as far as I knew, at that point in
 8 time. I would have known if they -- if Lucy Letby were
 9 to go back because I was in contact with Steve at that
 10 point.
 11 So once, you know -- I didn't know that they were
 12 withholding the neonatal case review report. I wasn't
 13 aware of that until I read all the emails, but
 14 I expected that as soon as that review was done the
 15 report would be available and I didn't know that was
 16 going to be delayed and that it was being withheld.
 17 **Q.** You say you would have known if Letby was
 18 returned to the ward. It would be too late once she was
 19 actually returned to the ward, wasn't it? You would
 20 need to know at the point that the decision was being
 21 made --
 22 **A.** Yes.
 23 **Q.** -- so that you could have an input in it?
 24 **A.** Yes.
 25 **Q.** Did you know that in fact it was decided to

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1 talking from November through to the time we know the
 2 police became involved at the end of April -- did it
 3 occur to you to think: I really must make sure that the
 4 Local Children's Safeguarding Board is aware?
 5 **A.** So that is what I was trying to do by sending
 6 the letter to Alison Kelly because I would expect to
 7 discuss it with her first before escalating to the local
 8 Safeguarding Board or to LADO. That would be
 9 a discussion.
 10 I wasn't -- I didn't know at that time. I think
 11 she knew about everything all along but at that time,
 12 I didn't know what she knew and therefore I felt that
 13 I should talk to her first before the escalation because
 14 that is the process, to go through your safeguarding
 15 lead and at least have a discussion there and if she
 16 doesn't agree then that's something else you would
 17 escalate by a different means.
 18 **Q.** We know you didn't send the letter. Did you
 19 speak to Alison Kelly about this before 27 April of
 20 2017?
 21 **A.** No.
 22 **Q.** Why not?
 23 **A.** Well, I was sending the letter as a means of
 24 opening a discussion but that never happened.
 25 **Q.** Well, why didn't you send the letter?

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1 A. Because I was waiting for the neonatal report,
 2 I was waiting ...
 3 There was also a culture of fear as well. So it's
 4 a very sensitive issue. The Consultants were threatened
 5 to lose their jobs, they were told that a red line is
 6 drawn under this and they didn't want any more
 7 discussions about this and they all didn't know what to
 8 do. So there was sort of -- I had to take it
 9 sensitively and I wanted more evidence to support me.
 10 Q. I mean, you are the person as the named doctor
 11 to ensure that this organisation meets its safeguarding
 12 responsibilities. Wasn't it your responsibility to
 13 become involved as soon as you could and to stay
 14 involved to make sure that that obligation was
 15 discharged?
 16 A. Yes, I agree, I should have escalated it
 17 earlier.
 18 Q. The second part is the safeguarding report,
 19 INQ0004715. Now, this is for 2016-17.
 20 Now, it's authored by Karen Milne, but presumably
 21 it is a document that you will have read and potentially
 22 contributed to as it was being drafted?
 23 A. Yes.
 24 Q. And we will just look at page 7 first,
 25 paragraph 6.3. Described in it, not by any particular
 221

1 You knew that your role was to see past that and to
 2 focus single-mindedly upon the safety of the children.
 3 Do you think that you did that?
 4 A. No, I should have escalated it earlier,
 5 I agree with that.
 6 Q. Page 19, please. I think we are looking at
 7 paragraph 11.5. We can see under the heading "Neonatal
 8 Unit Investigation" that there is a short summary given
 9 of events. What is not there is anything about the
 10 concerns of the Consultants or the fact that
 11 a safeguarding issue had been raised.
 12 Should that have been included otherwise, isn't
 13 this misleading?
 14 A. Yes. I didn't contribute to this. I don't
 15 know who, who did, whether -- I have heard my previous
 16 colleague Paula Lewis who said that to Alison Kelly, or
 17 it could have been somebody else, or whether it's
 18 Dr Mittal. I don't know who's put that paragraph there.
 19 Q. But presumably you read it though at the time?
 20 A. Yes.
 21 Q. And presumably you knew from what you had been
 22 told by this stage that it was misleading in the sense
 23 it didn't include that additional detail?
 24 A. Yes.
 25 Q. Knowing that it was misleading, did you say
 223

1 reference to any particular event, is the description of
 2 the LADO, the local area designated officer -- the Local
 3 Authority Designated Officer.
 4 We can see at the second sentence:
 5 "The LADO must be contacted within one working day
 6 in respect of all cases in which it is alleged that
 7 a person who works with children has behaved ..."
 8 I mean, that's a perfectly conventional
 9 understanding from a safeguarding perspective, isn't it?
 10 A. Mm-hm.
 11 Q. And you knew in this case that the LADO had
 12 not been contacted within 24 hours of the allegations
 13 being raised, didn't you?
 14 A. Yes, but it wasn't as clear-cut as this
 15 because it -- they were told that it's a coincidence,
 16 it's increased mortality and you can't blame somebody
 17 because of statistics. And so it, it wasn't clear
 18 allegations, it wasn't -- initially they were looking
 19 for medical causes as well. So it wasn't as clear-cut
 20 as where there is a clear allegation or a clear incident
 21 and that's why they didn't raise it as safeguarding.
 22 Q. Dr Isaac, you have told us that you as
 23 a safeguarder had special training to understand that as
 24 we saw at Addenbrooke there will be "initial
 25 disbelief -- must be an explanation."
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1 anything?
 2 A. No, and I can't remember when I read this
 3 either.
 4 **MR DE LA POER:** Thank you very much indeed for
 5 answering my questions, Dr Isaac. There is one
 6 permission, but I don't know whether or not all matters
 7 have been ... I am told there is one short matter.
 8 **LADY JUSTICE THIRLWALL:** Would you like to come
 9 forward.
 10 Questions by MS WOODS
 11 **MS WOODS:** Thank you, Dr Isaac. My name is
 12 Leanne Woods, I am asking some questions on behalf of
 13 a group of Families.
 14 I have just got one matter I wanted to deal with
 15 you, please.
 16 I have read your witness statement, others have
 17 read your witness statement and I want to ask you about
 18 some of the reasons for your inaction after you learnt
 19 of Dr Brearey's suspicions and I think also the inaction
 20 of others that you have given in your witness statement.
 21 So as I read your statement, you are saying,
 22 amongst other things: this was uncharted territory,
 23 you and others were not clear about what to do. Do you
 24 agree with that?
 25 A. Yes.
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1 Q. You also said that the various hospital boards
 2 and committees were not suitable for examining these
 3 kinds of issues, including because of the sensitivity of
 4 the matter, is that right?
 5 A. Yes.
 6 Q. Would you also agree that if there is
 7 a suspicion that a healthcare professional may have
 8 committed what was an incredibly serious criminal
 9 offence against babies that Executives are not equipped
 10 to investigate this kind of thing?
 11 A. (Nods)
 12 Q. Just for the record, if you could answer
 13 rather than simply nodding.
 14 A. So I would say, like we discussed previously,
 15 the escalation process would be the Freedom to Speak and
 16 discussion with referral to LADO; that would have been
 17 the right route to follow.
 18 Q. Okay. And part of the reason is that if
 19 people are thinking that there may be these incredibly
 20 serious criminal offences being committed,
 21 Executives/healthcare professionals just don't have the
 22 skills or the equipment to investigate that kind of
 23 thing, do they?
 24 A. No.
 25 Q. Given those factors, do you agree that this

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1 in those circumstances wouldn't seek to keep the
 2 concerns in-house, would they? They would go out to the
 3 established multi-agency arrangements?
 4 A. Yes.
 5 Q. And that's what should have happened here?
 6 A. Yes. Yes.
 7 **MS WOODS:** Thank you, my Lady. Thank you,
 8 Dr Isaac.
 9 **LADY JUSTICE THIRLWALL:** Ms Woods, thank you very
 10 much.
 11 A. Thank you.
 12 **LADY JUSTICE THIRLWALL:** I have no questions for
 13 you. Thank you very much indeed for coming, Dr Isaac.
 14 A. Thank you.
 15 **LADY JUSTICE THIRLWALL:** Thank you. So we will
 16 rise now until 10 o'clock tomorrow morning.
 17 Thank you all.
 18 (4.43 pm)
 19 (The Inquiry adjourned until 10.00 am,
 20 on Tuesday, 19 November 2024)
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1 is -- what was encountered with Letby was exactly the
 2 kind of circumstances where safeguarding professionals
 3 like you and Executives should be looking outside of the
 4 Trust?
 5 A. Yes, yes.
 6 Q. And you should be looking to the local
 7 multi-agency safeguarding arrangements that already
 8 existed and that specialise in responding to and
 9 investigating safeguarding concerns?
 10 A. The local -- sorry?
 11 Q. The local multi-agency safeguarding
 12 arrangements. So things like, well, we've talked about
 13 the LADO already?
 14 A. Yes, yes.
 15 Q. The local safeguarding children's board?
 16 A. Yes.
 17 Q. CDOP, if relevant, and of course also the
 18 police, do you agree?
 19 A. Yes, yes.
 20 Q. And of course that is what would have happened
 21 if healthcare professionals or indeed Executives in the
 22 hospital had had concerns that a child was suffering
 23 harm or was at risk of harm at home in the community?
 24 A. Yes.
 25 Q. Because healthcare professionals in the Trust

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